Nurses' views on compassionate care: a study using Q methodology

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Abstract

Compassion and compassionate care are identified as essential elements in nursing. They enhance quality care, wellbeing, and the overall quality of patients' lives. However, incidents of substandard care have highlighted inherent tensions between competing professional and organisational demands in a rapidly changing workplace. This research investigated nurses' views of the promoters and inhibitors of provision and maintenance of compassionate care. Participants were third year student nurses and qualified nurses in a large inner-city Trust hospital.

An integrative literature review revealed three overarching themes that impact on nurses' ability to provide and maintain compassionate care. Sumner's (2008a) Moral Construct of Caring in Nursing as Communicative Action Theory (MCCNCAT) was applied as the theoretical framework.

Q methodology supported the investigation of subjectivity within an interpretive design. 54 statements were developed from the literature review and focus group participation, representing the breadth of debate on compassion and compassionate care. Participants (n=30) rank-ordered these statements onto a quasi-normal distribution grid (the Q sort). They provided post Q sort data via Report Sheets and semi-structured interviews; thematic analysis was used to explore interview data. Completed Q sorts were analysed using correlation and by-person factor analysis, resulting in two distinct factors. Some participants shared commonalities across factors and did not contribute to the construction of the factor estimates. Remaining participants (n=18) included student nurses (n=10) and qualified nurses (n=8).

Compassionate care was found to be complex, interconnected, and multifaceted. There was consensus from student nurses and qualified nurses in the three overarching themes:

- *Personal/relational* – Improved patient outcomes impact positively on patients and motivate nurses to provide compassionate care. Satisfaction gained from providing compassionate care creates a virtuous circle, enhancing wellbeing, personal motivation, professional commitment, and job performance. It supports collegial relationships and positive patient outcomes.
- *Organisational* – Organisations must promote compassionate care, supporting nurses and providing necessary resources. Managers, leaders, mentors, and colleagues should demonstrate compassion towards patients and staff. Developing and supporting a culture of compassion can counter factors that inhibit compassionate care. Nurses should be encouraged to develop self-compassion, which promotes their own wellbeing.
- *Educational* – Nurses' clinical experiences should be connected to teaching and learning. This means replacing inappropriate didactic, classroom-based education with approaches that are experiential and creative, using strengthened links with practice, so that learning is relevant to the reality of clinical practice.

These findings were incorporated in an explanatory diagram, underpinned by MCCNCAT (Sumner 2008a) which makes visible the dynamics involved and strategies that build and sustain compassionate care.

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Acknowledgement to others

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Chapter One – Introduction

This thesis is based on a research study that investigated nurses' views of the factors that were perceived to promote or inhibit the provision and maintenance of compassionate care in nursing practice. It is set against a backdrop of reported incidents of sub-standard care in the UK, involving inhumane and non-compassionate care of some of society's most vulnerable members (The Patients Association 2009, 2011, 2012; Firth-Cozens and Cornwell 2009; Francis 2010, 2013; Care Quality Commission 2011; Health Service Ombudsman 2011; DH 2012a). These reports, and sustained media attention about the failings in treatment identified in the Francis report (2010, 2013), elevated the issue of compassion to the national agenda for the public, the profession, politically, and in higher education. The end result was a 'critical moment' for this issue as coverage resonated with widespread concern that health care is sometimes characterised by a lack of compassion.

Jeremy Hunt, the Secretary for Health and Social Care at the time of the Francis Inquiry stated:

> *These failings of basic human compassion represent perhaps the most shocking betrayal of NHS founding values in its history. And a betrayal of the vast majority of doctors, nurses and care assistants who joined the profession because of their innate compassion and humanity*"
>
> (The Telegraph, 5 February 2015)

Wright (2013) wrote in the Independent newspaper,

> *From the nurses who left patients in excrement-soiled bed clothes to the managers who only wanted 'good' news, to the Health Secretaries*

obsessed with financial targets, no-one emerges with credit from the Mid Staffordshire scandal.

Within this research I took an emic perspective as a nurse, a senior nurse academic, and researcher. Reflectively, as a nurse and academic I had always placed emphasis on the patient being at the centre of care, something I was passionate about. I was therefore disturbed by media reports and the findings from the Francis Inquiry (2010, 2013), that nurses were failing to uphold the values of the profession and failing to maintain the safety of the public (NMC, 2018a, 2018b). I wanted to contextualise the perspectives of student nurses and qualified nurses in the provision of compassionate care, to make recommendations for practice and education.

1.1 Context of the study

At its inception the NHS promoted comprehensive, universal, free health care, not influenced by government intervention. Nevertheless, enormous challenges have affected this ideal, including changing demographics, greater demand, rapidly evolving technology, information overflow (de Zulueta, 2016), and financial constraints (Karanikolos *et al*., 2013). The impact of the global economic crisis, triggering the acceleration of managerialist systems in public health systems globally (Allan *et al*., 2016, p.179) further exacerbated these challenges. Such transformations were followed by a focus on efficiency and productivity, characterised by shorter length stays in hospital, increased care intensity, fewer hospital beds and a reduction in human resources, particularly registered nurses (Ausserhofer *et al*., 2014; Aiken *et al*., 2014; Ball *et al*., 2014). The resulting cuts to funding for public health systems (O'Driscoll *et al*., 2018) subsequently incorporated job losses, vacancy freezing, 'down banding' of higher-grade nursing posts, and cuts to community, acute and mental health services (RCN, 2011; RCN, 2012). In contrast, improved patient outcomes,

including in mortality and patient satisfaction, are associated with improved staffing ratios of patients to nurses and nurse involvement in decision making (Aiken *et al*., 2002, p.1993; Kane *et al.,* 2007, p.1195; Aiken *et al*., 2011, p.1052; Aiken *et al*., 2012, p.14). The consequences of trying to do more with less were made explicit in the Francis Report (2013), which identified systemic failings, including routine neglect of patients, nurses lacking in professional behaviour, a management culture that valued financially driven targets over acceptable standards of patient care, management styles that discouraged staff from expressing concerns, and many more. The Francis Report (2013) made 290 recommendations which included an increased focus on delivering compassionate care. Consequently, it was recognised that poor quality care and lack of compassion impacts on the patient and the public, damaging the trust they have in nurses and confidence in the healthcare system (Francis 2010, 2013).

Following such high-profile scandals and condemnatory reports, more stringent regulations, new laws, and compassion initiatives emerged, including the renewal of core professional values (Francis, 2010, 2013; Abraham, 2011; DH, 2012a; Berwick, 2013, NMC, 2018a, 2018b). Examples of this include 'Compassion in Practice, Nursing, Midwifery and Care Staff: Our Vision and Strategy (CiPVS)' (DH, 2012c). This strategy outlined proposals for the development of a culture of compassionate care, building on the NHS constitution (DH, 2009) and the White Paper, 'Caring for our Future' (DH, 2012b). CiPVS (DH, 2012c) is based on six values; care, compassion, competence, communication, courage, and commitment, referred to as the 6 Cs. Following on from CiPVS (DH, 2012c) the word 'compassion' was incorporated into healthcare strategy, policy, recruitment, and education (Mclean, 2012; Fry *et al*., 2013; Waugh *et al*., 2014). Also, Health Education England (HEE, (2014) developed a national values-based recruitment (VBR) framework to be implemented by NHS

employers and Higher Education Institutions (HEIs). This framework focused on recruiting staff whose values and behaviours align with the values of the NHS Constitution, consequently impacting on both student and NHS staff recruitment.

1.2 Background to the thesis

Compassion and compassionate care are viewed as fundamental concepts for nursing (Schantz, 2007; van der Cingel, 2009; Burnell, 2009; Burnell and Agan, 2013; Sinclair *et al*., 2016a) with compassion described as "nursing's most precious asset" (Schantz, 2007, p.48). Von Dietze and Orb (2000) and van der Cingel (2009) suggest compassion is a complex phenomenon and is difficult to define. Nevertheless, both compassion and compassionate care are increasingly recognised as enhancing quality patient care, wellbeing, and overall quality of life, and as something nurses are expected to deliver (von Dietze and Orb, 2000; Maben, Cornwell and Sweeney, 2010; Paterson, 2011; Francis, 2013; Maclean *et al.,* 2014; Willis, 2012, 2015; Sinclair *et al.,* 2016b). Tuckett (1999) indicated that, in practice, a caring nurse exercises the virtue of compassion, engaging in a patient's experience, and enabling them to retain their independence and dignity (von Dietze & Orb, 2000; Papadopoulos *et al.,* 2016a). Such practice has been described as responding with humanity and kindness to the needs of another, to provide comfort (DH, 2012c) and relieve suffering (Schantz, 2007; Adamson *et al*., 2011; Curtis, 2013; de Zulueta, 2016).

Legally and ethically, nurses have a *duty of care* to protect the interests of the patient, to act as an advocate and to demonstrate competence (Thompson, Melia, and Boyd, 2000; NMC, 2018a, 2018b). Professional ethics in nursing inform the values, rights, duties and responsibilities of nurses when interacting with patients and colleagues. Nurses must practise in a way that will not cause avoidable harm to the patient (Thompson, Melia, and Boyd, 2000; NMC 2018a, 2018b). Alongside being competent

in their practice, nurses are required to demonstrate compassion as one of the five professional values (International Council of Nurses, 2012) evidenced in ethical guidelines for nurses around the world (e.g. American Nurses Association, 2015; Canadian Nurses Association, 2017; Nursing and Midwifery Board of Australia, 2018; Nursing and Midwifery Council, 2018a, 2018b). The requirement for compassion in care is also enshrined in the NHS Constitution (DH, 2009), the Health and Social Care Act (2012) and the Care Act (DH, 2014).

From an educational perspective HEE (2015), Francis (2010, 2013), and Willis (2012) emphasised the importance of developing compassionate practitioners. The Willis report (2012) suggested that nurse educators must plan, develop, and deliver a curriculum that seeks to equip nurses with the knowledge and skills required to engage in compassionate care. The Francis Report (2013) targeted pre-registration nurse education, suggesting nurses need to be assessed for their caring attributes, although that report did not present evidence that student nurses did not display caring attributes, or that their caring skills were not assessed at interview or during their studies. In the NMC standards for education and training, set out in three parts (NMC; 2018c, 2018d, 2018e), there is no reference to compassion and compassionate care. Each document identifies that nurses "must practise in line with the requirements of The Code" (NMC; 2018c, 2018d, 2018e), in which the requirement for compassionate practice is explicit. Nevertheless, it is important that the educational standards for nursing should guide curriculum development and implementation, to support the development of the skills, knowledge and attitudes required to deliver care with compassion (Horsburgh and Ross, 2013; Bramley and Matiti, 2014).

Nurses learn from both their educational and practice experiences, and literature suggests that individual values can change when they are exposed to the reality of

practice (Curtis, Horton and Smith, 2012; Bramley and Matiti, 2014; Richardson, Percy and Hughes, 2015). Consequently, even if students are recruited with the right values these can change, when exposed to dissonance between professional ideals and practice reality (Richardson, Percy and Hughes, 2015). There is ongoing debate related to the teachability of compassion and whether it can be nurtured or is simply an innate quality. This presents an ongoing challenge to nurse educators who must re-examine their approaches to the teaching of compassion. Cultivating compassionate care, Sumner (2008a) suggests, means that nursing knowledge must be applied competently, thoughtfully, and creatively.

Providing care with compassion has positive consequences for both patients and nurses. It plays an important role in improving patient outcomes (de Zulueta, 2016; Braithwaite *et al.,* 2017), enhancing patient wellbeing (Benner, Tanner and Chesla, 2009; DH, 2012c; Gilbert, 2010), and promoting both physical and mental health (Gilbert, 2010; Crawford *et al.,* 2014). The quality of care can be enhanced through establishing meaningful nurse-patient relationships (van der Cingel, 2011; Dewar and Christley, 2013; DH, 2012c), thereby alleviating distress and fostering contentment, coping, confidence, satisfaction, and empowerment (Gilbert, 2010). Also, fostering nurses' internal motivation to care may increase the frequency of caring behaviours, resulting in a sense of job satisfaction which positively influences nurses' job performance and longevity within nursing (Burtson and Stichler, 2010; Hayward and Tuckey, 2011), as well as enhancing recruitment and retention (HEE, 2014). Hunsaker *et al*., (2015) suggest caring behaviours can be sustained by providing support from experienced nurses, enhancing motivation and job satisfaction in less experienced nurses. Also, building a supportive environment can contribute to the retention of knowledgeable, caring, experienced nurses (Hunsaker *et al.* 2015).

Nonetheless the immense difficulties and challenges faced by nurses in their everyday practice cannot be ignored. Research has recognised the negative impact of the increased complexity of care provision, pressure to meet economically and politically driven targets, high turnover of nurses and a challenging work environment (Aiken *et al.,* 2002; Taylor & Barling, 2004; Jackson, Firtko and Edenborough, 2007; Aiken *et al.,* 2014; Ball *et al.,* 2014). Responding to constantly changing demands means that nurses "need to be endlessly flexible and adaptable'' (Sumner, 2003, p.166). The result for some nurses can be disillusionment and dissatisfaction, resulting in distress caused by not being able to provide quality care, and this can lead to a decision to leave nursing (Burtson and Stichler, 2010). The demands placed upon nurses can impact on their wellbeing, exerting a physical or emotional toll on nurses which is recognised in the literature as 'emotional labour' (Hochschild, 1983; Smith, 1992), compassion fatigue, and burnout (Sabo, 2011; Ledoux, 2015). Firth-Cozens and Cornwell (2009) identified stress and burnout as key factors in reducing the delivery of compassionate care as each of these can lead nurses to depersonalise patients. Engaging in self-care strategies, such as demonstrating self-compassion, can benefit nurses because, if they are to be compassionate to others it is important for them to be compassionate towards themselves (Sumner, 2008a; Dewar and Christley, 2013).

Compassionate care is shaped by the relationship between the nurse and patient, and is influenced by the practice environment and the provision of learning opportunities within the practice and education setting. Compassionate care is also required by government and professional bodies and is a public expectation. It is therefore a shared responsibility and is not solely about the individual performance of nurses (Crawford *et al.,* 2014). To achieve compassionate care, action at policy, organisational and educational levels is required.

1.3 Purpose of the study

Compassionate care occurs in the relationship between nurse and patient, and is influenced by political and sociocultural contexts in an ever changing and demanding healthcare environment. The purpose of this study was to investigate the viewpoints of both student nurses and qualified nurses on the promoters and inhibitors to compassionate care in their daily practice and to identify the strategies they use to achieve and maintain compassionate care, amid competing clinical practice pressures and priorities. The findings could identify strategies to help the nurse, the organisation, practice, and education to better support the enablers to compassionate care and respond to any challenges.

1.4 Potential implications for practice

With increased understanding, the challenges and the support necessary in providing compassionate care can be identified, helping practitioners, organisations, practice, and education to address challenges more effectively in the future. Illuminating strategies and frameworks for supporting compassionate care will contribute to embedding it into nursing practice. This research will therefore be of interest to nurses, other health care professionals, healthcare employers, managers, Higher Education Institutions and providers of in-service training.

1.5 Positioning myself as a researcher

I am an interpretive qualitative researcher; I view reality as subjective and as differing from person to person (Guba and Lincoln, 1994). Our experiences of the world involve participation in it (Heron and Reason, 1997), and can only be understood from the position of the individuals who are participating in it (Cohen, Manion and Morrison, 2007). Consequently, individuals construct many realities through interaction between language and the independent world (Guba and Lincoln, 1994). By investigating

patterns of interaction, I sought to explore the life world of individuals and, through the subjective nature of social reality, the perspective of participants (Holloway and Wheeler, 2010 p.6) in relation to compassionate care.

Q methodology offered a structured framework to explore the subjective viewpoints of nurses, how they viewed compassionate care, and how they related information from the external world to themselves. Q methodology enabled the identification of specific areas that have commonality or differences, enabling subjective communicability to be available for objective analysis (Watts and Stenner, 2012). It supported my position as an interpretive qualitative researcher, combining the strength and rigour of both qualitative and quantitative research methods (Brown, 1996).

A more in-depth discussion of Q methodology and my positionality as a researcher will explored in Chapter Three.

1.6 Theoretical framework

Eisenhart (1991, p.205) defined a theoretical framework as, "a structure that guides research by relying on a formal theory…constructed by using an established, coherent explanation of certain phenomena and relationships." From the integrative literature review (ILR) it became clear that caring, communication and relationship building are at the heart of compassionate care. Sumner (2007) identified that nurse and patient create a unique relationship to which they bring their historical and cultural backgrounds in a specific health/illness situation, where they are equals with assumed roles. The nurse brings their personal and professional self to the interaction and the patient brings their personal and illness self (Sumner, 2008a). As a result of this unique relationship both are inherently exposed and therefore vulnerable, requiring "considerateness" (regard or thoughtfulness for others and their feelings) (Sumner and Fisher, 2008, E21). Sumner (2008a) proposed that nursing is a moral, bi-directional

activity between the nurse and patient which is characterised by care and compassion. Sumner's (2008a) Moral Construct of Caring in Nursing as Communicative Action Theory (MCCNCAT) was selected as the theoretical framework on which to build insight and understanding of the provision of compassionate care.

1.7 Structure of the thesis

The thesis is organised in six chapters. This chapter has offered an introduction. Chapter Two presents a critical review of available literature related to compassion, and the provision of compassionate care, in the context of nursing practice.

Chapter Three details the theoretical and conceptual underpinnings of the study, giving the rationale for the choice of research methodology and research design. The findings from the research are presented in Chapter Four. Analysis and discussion of the findings, in relation to the literature and the research questions, are presented in Chapter Five.

Finally, the overall conclusions and implications for practice from a policy, educational and professional viewpoint and opportunities for future research are discussed.

Chapter Two – Integrative literature review (ILR)

This chapter explores the nature of compassion and the challenges and enablers in the provision of compassionate care in the context of nursing practice. A comprehensive approach was undertaken to reviewing and evaluating literature, in order to enhance understanding of the nuances of compassionate care giving.

2.1 Rationale for conducting an integrative literature review.

The literature did not lend itself to a systematic review as there were diverse methodological approaches and there have been no randomised controlled trials in this field. The review utilised the integrative literature review (ILR) framework of Whittemore and Knafl (2005) as the broadest type of research review method. This framework allowed for the inclusion of a diverse range of literature and varied methodologies, creating a more balanced evidence review and enhancing the holistic understanding of the topic in question (Whittemore and Knafl, 2005).

The integrative review was structured using the five stages described by Whittemore and Knafl (2005), presented in Table 1:

Table 1 – The five stages of Whittemore and Knafl's (2005) ILR framework
1. Problem identification 2. Literature review 3. Evaluation of data 4. Data analysis 5. Interpretation and presentation of results

2.2 Stage 1 – Problem identification

This stage aims to identify the problem under investigation and the review purpose. To achieve this, definitions of compassion will be discussed, followed by an exploration of the development of compassion. Compassion will be discussed as an emotion, and a virtue, with associated moral, professional, and legal obligations. Philosophical and

theoretical perspectives will illuminate the relationship of compassion and compassionate care giving with nursing and guide the focus of the integrative review process.

2.2.1 Compassion in the context of nursing

The significance and value of compassion has been recognised in conceptual, philosophical, religious and cultural beliefs and values. The word 'compassion' is derived from Latin – *com* (together with) and *pati* (to suffer), literally "to suffer with" (von Dietze and Orb, 2000, p.168). In its purest form it denotes the sense of suffering with those who suffer. To gain further insight and understanding a range of definitions were selected to reflect conceptual, philosophical, religious and cultural perspectives on compassion (Table 2). Definitions from nurse theorists such as Jean Watson, psychologists such as Richard Lazarus, Harvey Chochinov and Paul Gilbert, and the historian of religion, Karen Armstrong, were included. All have produced seminal work that contained new ideas and had a great influence in their specific fields of study, influencing the understanding and interpretation of compassion, and consequently compassionate care.

Table 2 – Definitions of compassion from varying perspectives

Author	Underpinning perspective	Definition	Actions expressed in the definition.
Armstrong (2011, p.4)	Religious and historical perspective.	"The principle of compassion lies at the heart of all religious, ethical and spiritual traditions, calling us always to treat all others as we wish to be treated ourselves. Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there, and to honour the inviolable sanctity of every	*Treating* others as we wish to be treated. Recognising the needs of the individual. *To work* tirelessly to alleviate suffering. *To honour* and *protect* the

		single human being, treating everybody, without exception, with absolute justice, equity and respect."	rights of individuals.
Feldman and Kyken (2011, p.143)	Buddhist perspective	"Compassion is a multi-textured response to pain, sorrow and anguish. It includes kindness, empathy, generosity and acceptance. The strands of courage, tolerance and equanimity are equally woven into the cloth of compassion. Above all compassion is the capacity to open to the reality of suffering and to aspire to its healing."	*Responding* to pain, sorrow and anguish. Acknowledging the reality of *suffering.* suffering. To *aspire* to healing. The wish to relieve suffering.
Papadopoulos (2011, p.3)	Cultural perspective	"Cultural competence is the capacity to provide effective and compassionate healthcare taking into consideration people's cultural beliefs, behaviours and needs".	*To provide* effective and compassionate healthcare. *Taking* into *consideration* the needs of the individual including their cultural beliefs, behaviours and needs.
Gilbert (2010, p.xiii)	Psychological perspective	"Compassion can be defined in many ways, but its essence is a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it."	*Awareness* of oneself. *Awareness* of and wish to relieve *suffering.*
NHS Constitution (DH, 2009, p.12)	Healthcare perspective	Compassion requires the response of ''humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.''	*Responding. Searching* for things we can do to give *comfort and relieve suffering*. To *serve*, *work* alongside. To *care.*
Watson, (2009, p.479)	Nursing perspective	"consistent with the wisdom and vision of Florence Nightingale, nursing is a lifetime journey of caring and healing seeking to understand and preserve the	*Caring. Healing. Seeking to understand. Offering.*

		wholeness of human existence, and to offer compassionate, informed, knowledgeable human caring to society and humankind." Watson defines compassion as the "capacity to bear witness to, suffer with, and hold dear within our heart the sorrow and beauties of the world."	*Informing.* *Suffer w*ith. To *witness.* To *hold.*
Chochinov (2007, p.184)	Psychological perspective	"A deep awareness of the suffering of another coupled with a wish to relieve it."	*Awareness* of and wish to relieve *suffering.*
Lazarus (1991, p.289)	Psychological perspective	"Compassion…is not a sharing of another person's emotional state, which will vary depending on what the other person's emotional experience seems to be, but an emotion of its own…In compassion, the emotion is felt and shaped in the person feeling not by whatever the other person is believed to be feeling, but by feeling personal distress at the suffering of another and wanting to ameliorate it. The core relational theme for compassion, therefore, is being moved by another's suffering and wanting to help."	*Feeling* and *shaping* our emotions in response to another's distress and suffering. Being *moved* by another's suffering. Wanting to *help* another. Wanting to *ameliorate* suffering.

These definitions contain actions that involve thinking, feeling, motivation and behaviour, doing something for another person (helping, comforting, relieving, responding, offering, seeking to understand, considering, working to alleviate suffering, suffering with, honouring and protecting). The majority involve recognition, acknowledgement and a response to suffering (Lazarus, 1991; Gilbert, 2010; Chochinov, 2007; DH 2009; Watson, 2009; Armstrong, 2011; Feldman and Kyken, 2011). From the definitions it is recognised that compassion involves human relationships, what is expected of them, and how we care (Lazarus, 1991; DH 2009; Gilbert, 2010; Armstrong, 2011; Feldman and Kyken, 2011; Papadopoulos, 2011), and

that it requires us to enter the patient's experience (Lazarus, 1991; Chochinov, 2007; Watson, 2009; Gilbert, 2010; Armstrong, 2011; Feldman and Kyken, 2011; Papadopoulos, 2011). Compassion is thought to be an emotional antecedent to altruistic behaviour, the response of caring for and wanting to relieve suffering (von Dietze and Orb, 2000; Goetz, Keltner and Simon-Thomas, 2010). von Dietze and Orb, (2000) and Kneafsey *et al.,* (2015) suggest it is intentional, deliberate and voluntary behaviour in support of another person, that is not given with the expectation of reward or punishment. Nevertheless, when applied to nursing, McAllister and Ryan (1996) associate the inter-relational consequences of a good act as having a positive effect on the nurse's character, and therefore the act benefits the nurse personally. Therefore, there is a two-way relationship. The nurse shares an emotional experience with the patient, actively giving of themselves, demonstrated through an awareness and desire to prevent or alleviate suffering and distress. The patient chooses to trust the nurse and invest in the relationship.

Papadopoulos (2011) emphasised that cultural competence is required in the provision of compassionate care, to respond to the cultural beliefs, behaviours and needs of the patient. This involves synthesis of the knowledge and skills the nurse acquires during their personal and professional lives (Papadopoulos, Tilki and Taylor 1998) and contributes to the compassionate relationship.

From the definitions it is evident that relationships are central to compassion and involve giving and receiving. As Von Dietze and Orb (2000, p.169) suggest it "is not so much about what we choose to do for other people, but what we choose to do together with them". From this shared, authentic and meaningful relationship suffering can be understood and acted upon (Pellegrino and Thomasma, 1993; Schantz, 2007; Sinclair *et al.,* 2016d).

From an evolutionary perspective, the development of compassionate relationships emerged as an affective element of a caregiving system (Goetz, Keltner and Simon-Thomas 2010). Compassionate individuals were preferred in mate selection as more likely to provide physical care, enhancing the welfare of vulnerable offspring and ensuring replication of genes, which is essential to survival (Goetz, Keltner and Simon-Thomas, 2010, p.5). Distinct appraisal processes resulted in distinct behaviours, contributing to cooperative caring communities (Goetz, Keltner and Simon-Thomas, 2010) and the development of mutually beneficial relationships (Gilbert, 2010; Goetz, Keltner and Simon-Thomas, 2010).

When relating definitions to nursing, compassion can be recognised as becoming aware of, and responding to, the needs of another, and a shared relationship is integral to this. However, Schantz (2007) and Burnell (2009) suggested that several terms, such as pity, sympathy, empathy, and caring, are used interchangeably with compassion. Schantz (2007) suggested that to imply that these terms are synonymous promotes inaccurate assumptions. To provide further clarity it is important to distinguish compassion from associated concepts, such as pity, sympathy, empathy, kindness and caring (Pellegrino and Thomasma, 1993; Schantz, 2007; Goetz, Keltner and Simon-Thomas, 2010; DH, 2015; Sinclair *et al.,* 2016d).

It is suggested that pity is a feeling which conveys condescension and dissociation (Fox 1990; Rinpoche 1992), and involves concern directed towards someone considered inferior to the self (Ben Ze'ev, 2000; Fiske, *et al.*, 2002). Fox (1990) and Rinpoche (1992) suggest that feeling pity towards a person implies an assault on their dignity, resulting in a paternalistic approach to care. Sympathy is defined by Sinclair *et al.,* (2016d) as a superficial acknowledgement of suffering, invoking a pity-based response. It fails to acknowledge the person who is suffering and does not demand or

include action. Whereas Nussbaum (1996, 2001) suggests demonstrating compassion, and not merely pity or sympathy, requires an evaluation of circumstances to make a reasoned practical response. Empathy, Post *et al.,* (2014, p.873) suggest, is the ability to understand the depth of another person's feelings and accurately acknowledge and "resonate emotionally with that feeling to some degree". However, von Dietze and Orb (2000, p.169) propose that, although "empathy implies being touched by and understanding the reality of another person, it does not specifically require action." Consequently, van der Cingel (2014, p.1254) suggests empathy is an "ability that functions as a condition of compassion".

Pellegrino and Thomasma (1993, p.81) add that compassion has moral and intellectual aspects, it is one of the "caring or altruistic virtues". Blum (1980, p.509) suggests that,

> Compassion is not a simple feeling state but a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, [involving] emotional responses of a certain degree of intensity.

Consequently, compassion can be distinguished from pity, sympathy, and empathy, as it involves establishing authentic and meaningful relationships through which suffering can be understood and acted upon (Pellegrino and Thomasma, 1993; Schantz, 2007; Sinclair *et al.,* 2016d).

The concept of kindness involves authenticity, whereby emotional response and behaviour are attuned and this comes from "generosity, empathy, and openheartedness" (Ballatt and Campling, 2011, p.16). Ballatt and Campling (2011) suggest there is an overlap between the concepts of compassion and kindness, with

compassion implying suffering with another, whereas kindness is linked to the concept of kin and kinship. Kindness is “something that is generated by an intellectual and emotional understanding that self-interest and the interests of others are bound together” (Ballatt and Campling, 2011, p.4). Kindness and the embodiment of kinship are therefore important in the compassionate relationship (Ballatt and Campling, 2011).

Compassion is also viewed as closely aligned to the broader concept of conveying care within nursing practice (Finfgeld-Connett, 2007; Crawford *et al.,* 2013; Horsburgh and Ross, 2013; Bramley and Matiti, 2014; Richardson, Percy, and Hughes, 2015). However, Cole-King and Gilbert (2011, p.30) suggest that “compassion is more than just caring… we can’t have compassion for inanimate objects… the object of compassion is another sentient being”. To explore this further, compassion is associated with recognising and responding to the needs of another. However, situations exist in which the patient is vulnerable and highly dependent on the nurse yet unable to express their needs. This is made evident when the nurse cares for the unconscious patient, who may not appear sentient (able to perceive and feel). The patient may have sustained a brain injury that results in reduced mental capacity, e.g., permanent unconsciousness, and as a result may not appear to be sentient. Nonetheless, as Sumner (2001) identifies, the confused, disoriented, or unconscious patient has a subliminal need to be recognised as a participant in the interaction of professional nursing care with associated rights and needs. Studies suggest the unconscious patient retains a degree of perception (Jones et al., 1994; Puggina et al., 2011), and encouraging communication can provide an effective means of early stimulation (Tosch, 1988; Podurgiel, 1990). The nurse provides care that involves mental, emotional, and physical effort, looking after, responding to, and supporting

others (Henderson, 2001). When caring for the unconscious patient, the nurse therefore assumes they are sentient and provides compassionate care as they would to all patients. By acting in this way, the nurse has recognised the legal and ethical rights of the patient and their own professional duty of care to the patient (Thompson, Melia and Boyd, 2000; Terry, Carr and Halpin, 2017), Accordingly, the nurse is acting in the best interest of the patient (Mental Capacity Act, DH 2005; NMC, 2018a) and is providing "safe, compassionate, and effective nursing care" (NMC 2018a, p.3).

There are several theories related to caring and Sumner (2006) identifies a number of these as comprehensive, including Leininger's (1988) theory of transcultural care diversity or Universality, Orem's (1985) self-care deficit theory, and Watson's (1985) theory of human science and human care. Nevertheless, she suggests all have limitations as they focus on caring as unidirectional, the nurse giving to the patient who in turn receives the care. Sumner (2008a) proposed in her Moral Construct of Caring in Nursing as Communicative Action Theory (MCCNCAT) that nursing is a moral, bi-directional activity, with both the nurse and patient giving and receiving in return. This activity characterises care and compassion, the outcome of which has the potential for growth and satisfaction for both.

The connection and differences between compassion and, pity, sympathy, empathy, kindness, and caring have been made evident. The emotions of pity and sympathy may acknowledge suffering, empathy leads to emotional resonance, and kindness supports compassion through kinship. Compassion, however, requires awareness of and desire to prevent or alleviate suffering and distress. The nurse shares an emotional experience with the patient, actively giving of themselves. It is argued therefore that compassion defines itself in the broader context of caring, inextricably linked to it as a symbiotic activity involving both the nurse and the patient.

2.2.2 Compassion as an emotion

Van der Cingel (2009) suggests that a feeling is a physical experience, whereas an emotion is of a more complex nature and motivates "specific patterns of behaviour towards others in need" (Goetz, Keltner and Simon-Thomas, 2010, p.4). An emotion has an object and is focused on something or someone; it is influenced by our values, beliefs, and experiences. This is captured in the definitions below:

> emotions are complex organised states consisting of cognitive appraisals, action impulses, and patterned somatic reaction.
>
> Lazarus, Kanner and Folkman, 1980, p.198

> [emotion is] a basic judgment about our selves and our place in our world, the projection of the values and ideals, structures and mythologies, according to which we live and through which we experience our lives.
>
> Solomon, 1993, p.126

Van der Cingel (2009, p.128) said "compassion is an emotion" that makes visible the suffering of a patient. Emotions require thought. It is not enough to simply witness suffering, to feel compassion a specific thought is required that suffering is a terrible thing.

Gross (2008, p.497) has discussed the role of "emotion regulation" by which feelings give rise to emotions. Gilbert (2010) says that experiences of emotions and desires emerge from the patterns created in our brains and bodies. He refers to three types of major emotion regulation systems serving various functions, each designed to do different things, and to be in balance with and counterbalance each other:

- A *threat and protection system* responds and takes action against threat to protect the self. Example: when overwhelmed by the demands placed upon

them, nurses might distance themselves from patients (van der Cingel, 2009; Ballatt and Campling, 2011) or depersonalise patients to avoid further emotional demands on themselves (Firth-Cozens and Cornwell, 2009).

- An *incentive and resource seeking system* motivates us to locate resources to help us survive and prosper. Example: nurses might be motivated to relieve the suffering of others (Cole-King and Gilbert, 2011) or to respond to deadlines, or complete required tasks (Ryan and Deci, 2000).
- A *soothing and contentment system* helps us achieve contentment and feel safe. Example: this could involve nurses seeking support from managers, leaders, and colleagues, practicing reflection and developing self-compassion (Dewar and Christley, 2013).

To explore emotions further, theories of emotion are represented in a continuum or range, running from an understanding of emotions as noncognitive, not necessarily requiring a belief or judgement, to seeing them as strongly cognitive, in which a judgement and evaluation is a prerequisite for an emotion (Lang, 1994; Nussbaum, 2001; Solomon, 2008; Newham, 2017).

To offer further insight, the James-Lange theory (cited in Lang, 1994) argues that emotions are primarily physical – interpretation of physiological changes occurs and cognitive interpretation results. For example, if you are frightened this is a result of interpretation of your physical reactions; you feel frightened *because* you are trembling, you do not tremble because you are frightened. In direct opposition, the Cannon-Bard theory of emotion (Sullivan, 2009) suggests you can experience physiological reactions linked to emotions without feeling those emotions. For example, your heart rate may accelerate due to exercise not because of fear. The

physical and psychological experiences of emotion happen at the same time and one does not cause the other. An alternative to both is the Schachter and Singer (1962) cognitive theory of emotion that proposes that emotions are inferred on the basis of physiological responses. The critical factor is the situation and the cognitive interpretation people use to label that emotion. For example, nurses in a cardiac arrest situation may associate their own increased heart rates with the emotion of anxiety, whereas the successful resuscitation procedure may result in the same physiological response, this time attributable to happiness.

Martha Nussbaum (2001, 2003) identified that emotions involve thought, judgment, and evaluation, thus having a cognitive dimension. Through our emotions and thoughts, we can understand others and ourselves. Nussbaum (2001) suggests personal histories and social norms shape emotions and we use our intelligence of emotions to orient ourselves in the world, to form judgements and to take decisions and actions. Consequently, Tschudin (2003) suggests, acting virtuously involves judgement. We are motivated by our thoughts, and Solomon (1980) adds that socio-cultural aspects influence emotions and views on emotions.

On the basis of this discussion, compassion is viewed as an emotion and a theoretical understanding that compassion in nursing is understood to involve thought, judgment, and evaluation is adopted in this research.

A challenge to be non-judgemental in nursing can be recognised in Aristotle's belief that only undeserved suffering should result in compassion (Nussbaum, 2001). To explore this further Nussbaum (2001) claims that, in so far as we think a person's plight is their own fault we will blame them rather than feel compassion, leading to anger and resentment as the sufferer is not deserving of compassion (Batson, 2011; Nussbaum, 2001). An exception to this is when suffering is out of proportion to the fault

(Nussbaum, 2001), but this presents a problem in deciding responsibility and subsequent deservedness of the sufferer. Professional ethics identify the right to equal treatment; accordingly, compassion means setting aside one's own interests, values and judgements and not giving judgement on the possible guiltiness of suffering (van der Cingel, 2009). Newham (2017) and van der Cingel (2009) suggest that the person experiencing suffering should make the judgement about deservedness as each sufferer perceives this differently (van der Cingel, 2009). Newham (2017) considers that an expression of compassion in nursing may be morally inappropriate, but professionally requisite. Professionally, nurses are required not to judge the patient and to put aside their own personal views and values or their feelings regarding a patient's lifestyle choices.

Nurses' expression of the emotion of compassion, their acknowledgement of suffering, and acting to alleviate it require emotional endeavour (Goetz, Keltner and Simon-Thomas, 2010) and engagement in emotional labour (Hochschild, 1983). Hochschild (1983) suggested that roles requiring emotional labour have three elements: having direct contact with the public; the need to produce an emotional state in other people; and a set of explicit or implicit rules regarding the types of emotional display that are appropriate and inappropriate. Smith (1992, 2012) concluded that nursing is a profession which involves considerable emotional labour as a role requirement.

Hochschild (1983) developed a theory of emotional labour postulated in an organisational setting, that workers are expected to act and feel in ways which meet organisational demands. Diefendorff *et al*., (2011, p.182) confirmed that nurses have "display rules" concerning the emotions that should be expressed and those that should remain hidden. This is referred to as "emotional regulation", feeling controlled by work environments (Diefendorff *et al*., 2011, p.171) and can result in increased

emotional labour. Hochschild (1983, p.218) described two aspects related to the management of one's emotions: "*surface acting"* and "*deep acting"*. Surface acting refers to following "organizationally prescribed display rules" (Bagdasarov and Connelly, 2013, p.126) that involves suppressing, or substantially changing, emotions to comply with organisationally defined rules and regulations. Examples include demonstrating positive emotions to a patient when feeling annoyed or angry, or when we encounter conflicting beliefs, attitudes or behaviour. "Deep acting emphasizes alignment of felt and expressed emotions in order to produce a more genuine emotional display" (Bagdasarov and Connelly, 2013, p.126). The nurse connects with the patient and is perceived as more authentic (Grandey *et al.,* 2012).

Emotional labour therefore has positive and negative consequences. Surface acting requires increased emotional labour and has been associated with emotional dissonance, resulting in emotional exhaustion (Msiska *et al*., 2014), which is a major factor in stress and burnout (Kinman and Leggetter, 2016). Deep acting has positive associations with job satisfaction and an increased sense of connection with patients, resulting in patient satisfaction (Chou, Hecker and Martin, 2012). Smith (1992) and de Zulueta (2013) suggest nurse education and clinical practice must facilitate methods to support nurses in their role and limit the negative impact of increased emotional labour.

2.2.3 Compassion as a professional value

Religious beliefs are based in cultivated assumptions that compassion will make for more morally coherent lives and more cooperative communities (Schantz, 2007; Bradshaw, 2009; Burnell, 2009; Gilbert, 2010; Armstrong, 2011). Gilbert (2010) suggests that the importance and power of compassion as a way of enhancing our

social relationships, and relationships with ourselves and our happiness, are evident in both spiritual and religious traditions.

Bradshaw (2009) asserts that the cultivation of the compassionate nurse was grounded in the Judaeo-Christian framework of moral values. This is encapsulated in the narrative of the "Good Samaritan", which teaches Christians to be compassionate in their actions (Bradshaw, 2009, p.466). Straughair (2012, p.163) believed "that compassion in nursing can be attributed to the Christian ideals translated by Florence Nightingale into the characterisation of the professional nurse". In Florence Nightingale's view (1859), good nurses were good people who cultivated certain virtues or qualities in their character, and this included compassion. She placed a strong emphasis on the moral and religious virtues that she believed were required. Accordingly nursing developed ideals and expectations for its members, and the virtue of caring has developed into an ethical ideal in nursing (Fry, 1989). Oppenheimer (1992, p.47) stated that "morality is about what ought to be done or not done, law is about what people can be compelled to do or not do". "A moral virtue is viewed as an acquired habit or disposition, a trait of character that guides an individual to act in accord with moral principles, rules and ideals" (Beauchamp and Childress, 2001, p.261). Tschudin (2003, p.8) suggests, "my own existence achieves its fulfilment or perfection by virtue of the way I care for others". Caring in this sense is viewed as a virtue and acting from this virtue will be acting well (Pellegrino, 1995) with 'the inherent goal of enhancing the health-related existence of those others" (Tschudin, 2003, p.8).

Pellegrino (1995) championed virtue ethics in healthcare, considering it a moral enterprise, with the patients suffering providing the moral impulse for the aims of care. This involves professionals in "…an act of implicit promise making that establishes a covenant of trust" (Pellegrino, 1995, p.267). Pellegrino (1995, pp.269-270) identified

essential virtues as, “fidelity to trust and promise benevolence, effacement of self-interest, compassion and caring, intellectual honesty, justice and prudence”. He believed the virtues need to be inculcated in practitioners to safeguard their practice (Pellegrino, 1985). Tschudin (1998) identified that at times of crisis people turn to another for help, and amongst the qualities and virtues required of another are that they are compassionate and just. A crisis can then be turned into a potential for human growth as a relationship develops and, because of this relationship, compassion becomes justice (Tschudin, 1998).

Armstrong (2011, pp.1-2) suggests all faiths have formulated versions of the Golden Rule requiring people to “always treat others as you would wish to be treated yourself”. Acknowledging that you cannot confine benevolence to your own group, you must have concern for everybody. Beauchamp and Childress (2001) suggest it is not just the competent performance of technical skills that evokes the image of caring – the essence of caring is captured in the compassionate attitudes and feelings of the nurses toward the patient as they provide care. Consequently, “compassionate care is an expression of the shared professional morality of nursing that is expected by the nurse, the patient, and the broader society in all contexts of healthcare provision” (Winch, Henderson and Jones, 2015, p.228).

In the UK, the requirement for compassion in care is enshrined in the NHS Constitution (DH, 2009), the Health and Social Care Act (2012) and the Care Act (DH, 2014). It is recognised internationally as a professional value (Canadian Nurses Association, 2017; American Nurses Association, 2015; NMC, 2018a). The NMC recognises the *duty of care* required of nurses to protect the interests of the patient and sets standards in relation to professional behaviour and practice, undergraduate education and continuing professional development (CPD) (NMC, 2018b, 2018c). The NMC (2018a,

p.3) states that the public can expect nurses to provide “safe, compassionate, and effective nursing care” and the interests of service users must come first. Legally, nurses are required to demonstrate competence and Parsons *et al.* (2001) suggest this incorporates having an up-to-date knowledge base and demonstrating the ability to achieve desired outcomes through the performance of defined skills. It is essential for nurses to maintain their competence to provide safe patient care and to commit to adhere to the code of professional conduct and its embodied values. Consequently, nurses must demonstrate compassion in their practice in order to be deemed competent.

2.2.4 Summary of problem identification

In this discussion compassionate care emerges as a complex, interconnected, multidimensional concept, involving cognitive, behavioural, and affective dimensions, in which emotion and reason are intertwined. It is positioned as a virtue within philosophical, religious, spiritual, and ethical thinking. The importance of compassionate care provision is embedded in professional guidelines and government policy, and is a public expectation.

The next section explores the literature related to factors that promote and inhibit the provision of compassionate nursing care.

2.3 Stage 2 – Literature search

The sampling frame for the literature review encompassed quantitative and qualitative data, as well as theoretical literature and policy. Electronic databases used included: Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus); Education Research Complete; Medline, Psychology and Behavioural Science Collection; PsycINFO; and SocIndex. In addition to keyword searching in databases, articles were identified by scrutinising the reference lists of selected papers, locating further

published work by prominent researchers in the field. Existing literature reviews and systematic reviews were prioritised as they helped to provide a synthesis of up-to-date knowledge. However, the scope of the literature was not just limited to these articles as wide reading produced further primary sources.

2.3.1 Eligibility criteria for literature review

The time span for this literature review was 2004 to 2019, a span of 15 years. This reflected the sustained growth of interest in the topic of compassion and compassionate care in policy, practice and research resulting from government inquiries and highly influential reports (DH, 2006, 2008, 2009; The Patients Association, 2009, 2011, 2012; Firth-Cozens and Cornwell, 2009; Francis, 2010, 2013; Care Quality Commission, 2011; Health Service Ombudsman, 2011; DH 2012b). Scrutiny of the reference lists of selected papers revealed further relevant research, for example the research paper by Graber and Mitcham (2004).

Studies were included in the final synthesis if they sampled nurses, student nurses, and patients, their perceptions of interventions to improve compassionate care, and promoters and barriers to its provision. Studies with non-clinical populations were excluded, as the focus was to explore compassion towards others in clinical care, as were studies that primarily focused on other related concepts (e.g., empathy, ethics, communication) or used interventions that aimed to foster self-compassion (e.g., mindfulness-based stress reduction, compassion-focused psychotherapy). This review explored categories that included: perspectives, clinical outcomes, knowledge, skills, or attitudes. Primary and secondary studies using qualitative, quantitative, or mixed-method designs were included. Letters, commentaries, editorials, conference abstracts and case studies were excluded. The search terms used are shown in Table 3.

Based on the search terms and inclusion/exclusion criteria, the initial search resulted in 4520 articles. Additional sources were identified through Google Scholar, reference lists of included articles, and data base alerts (n = 29). After removal of duplicates the

Table 3 – Search terms, inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Papers from 2004 to 2019. Key words and truncations: compassion, compassion and nurs*, compassionate car*, compassionate car* and nurs*, person centred car* and nurs*, nurs* practice, enablers, barriers, compassionate car*, and strategies. English language publication Peer-reviewed journals, dissertations, theses, and books. Research and conceptual studies. Qualitative, quantitative, or mixed methods studies. Policy and practice guidance. Government reports. Legal and professional requirements related/applicable to nursing.	Papers before 2004. Not peer reviewed. Not available in English language.

articles remaining totalled 2204. They were subsequently assessed for relevance based on title and abstract, resulting in 156 articles retrieved for full text review. Fifty articles met the inclusion/exclusion criteria for final synthesis. The process for refining and evaluating each stage is shown in Figure 1.

2.4 Stage 3 – Evaluation of data

2.4.1 Quality appraisal of selected studies

Whittemore and Knafl (2005) suggest that quality scores be incorporated into the data analysis stage. They recognise that this is complex as there is no gold standard for calculating quality scores. Additionally, each type of research design generally has different criteria that exemplify quality. Nevertheless, for the purposes of this research,

assessment was accepted as contributing to synthesising information, from which a holistic understanding of the provision of compassionate care could be drawn.

Two quality appraisal tools were utilised. To appraise qualitative studies *The Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields*, developed by Kmet, Lee and Cook (2004) was used. A scoring system developed by Kmet, Lee and Cook (2004) was used to evaluate the quality of qualitative studies, drawing on other published tools and guidelines suggested by Popay, Rogers and Williams (1998, pp.341-351) and Mays and Pope (2000, pp.89-101). The scoring exercise (Appendix 1) identified one study that was classified as less well designed, scoring 10/20 (50%). This study, by Jones *et al*., (2016), was nevertheless included in the literature search as it was one of the very few studies that focused on enablers and inhibitors to compassionate care (n=5). Additionally, this study identified issues "outside-the-workplace" that inhibit compassionate care. These included the nurse's social and family situation and accompanying support (Jones *et al*., 2016, p.3143), and had not been raised in other studies. The remaining studies (n=25) scored 13 to 16/20 (65-80%) and were classified as adequately designed. The scoring system ensured that studies met a minimum quality standard for inclusion (Kmet, Lee and Cook, 2004). Single scores and a summary critique of each study are reported in Appendix 2.

The Mixed Methods Appraisal Tool (MMAT), version 2018 (Hong *et al.,* 2018), was selected to appraise the quantitative and mixed methods studies. The MMAT was developed in 2006 (Pluye *et al.,* 2009), revised in 2011 (Pace *et al.,* 2012). Further development was based on findings from a literature review of critical appraisal tools, interviews with MMAT users, and an e-Delphi study with international experts (Hong *et al*., 2018). The MMAT comprises screening questions to establish the strengths and

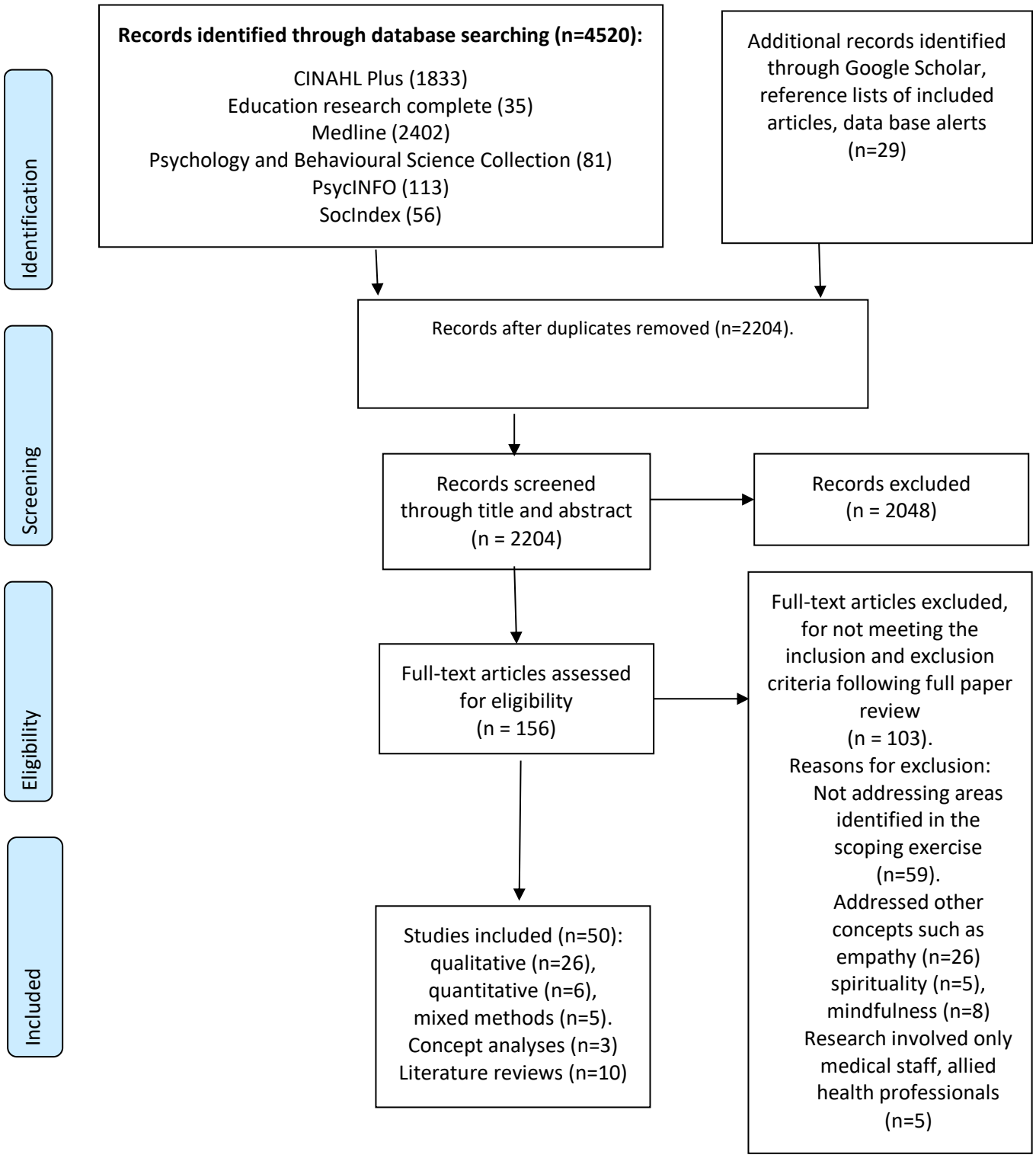
weaknesses of studies. In the 2018 version the use of metrics to score studies was discouraged as it was believed that presenting a single number rendered it impossible to know what aspects of studies were problematic. It was recognised that this presented challenges in reporting results. Consequently, the revised suggestion is that, as there are only a few criteria for each domain, the score can be presented using descriptors such as % (Appendix 3). The scoring within both the quantitative (n=6) and mixed methods (n=5) studies ranged from 60% to 80%, with the scores representing a classification of the indicators for inclusion. The individual scores and critique of each study are reported in Appendix 2.

There were varying levels of methodological strength and weakness, alongside limitations, in the studies. Nevertheless, they all contributed to the evidence base of the challenges and enablers of compassionate care in the context of nursing practice.

2.5 Stage 4 – Data analysis

A thorough and unbiased interpretation and synthesis of the data is the goal of the data analysis stage. The steps of data analysis comprised data reduction; data display; data comparison; data conclusion and verification. Data reduction involved displaying characteristics such as author, country of origin, study design, sampling, results, and critique of research. Data comparison was achieved by undertaking a constant comparative analysis to identify patterns, variations, and relationships resulting in theme development across the selected research studies. Consequently, the findings from data analysis were categorised and summarised in an integrated conclusion.

Figure 1 - PRISMA 2009 Flow Diagram – search 2004 to 2019



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

2.5.1 Interpretation and presentation of the data: an overview of the studies in the final review

Research studies (n=37), concept analyses (n=3) (Appendix 2), and literature reviews (n=10) (Appendix 4) were included in the final review. In the 37 studies, qualitative (n=26), quantitative (n=6), and mixed methods (n=5) approaches were employed. There were a limited number of studies with the specific aim of investigating enablers and barriers to providing compassionate care in nursing (n = 5) (Horsburgh and Ross, 2013; Christiansen *et al.,* 2015; Jones *et al*., 2016; Singh *et al*., 2018; Babaei and Taleghani, 2019).

Concept Analyses

Concept analyses of both compassion (Schantz, 2007) and compassionate care (Burnell, 2009) linked the demonstration of compassion with being compassionate. Schantz (2007) went on to explore compassion from a religious, philosophical, and professional perspective, suggesting compassion is not an inherent quality that individuals possess but an individual choice and a moral virtue. Burnell's (2009) work has strong religious undertones, with no mention of how compassionate care can be provided when religious beliefs are not included. To illustrate this, "The fruit of the Holy Spirit" was identified as a defining attribute of compassionate care (Burnell, 2009 p.3) and questionable reference sources included *God on the Net*. Nevertheless, both Schantz (2007) and Burnell (2009) agreed that for compassion to be realised, suffering must be identified, acknowledged, and acted upon.

Sumner's (2006) concept analysis explored interrelated concepts, specifying their relationship and creating an operational definition of caring in nursing. This enabled instrument development to test a theoretical framework (Sumner and Fisher 2008), from which was created the MCCNCAT (Sumner 2008a). The strength of the concept

analysis was the emphasis on the bidirectional communication underpinning the nurse patient interaction and how the needs of both are met, highlighting their vulnerability and need for considerateness. The outcomes of caring in nursing as communicative discourse were identified as: <physis> or blossoming, growth, validation and satisfaction.

The qualitative studies

The qualitative studies (n=26) emanated from the following countries: Australia (2), Canada (6), Iran (1), Netherlands (1), Norway (1), UK (11), USA (4).

Qualitative designs included, ethnographic studies (n=2), grounded theory (n=8), exploratory/descriptive (n=4), appreciative Inquiry (n=4); action research (n=1), phenomenological studies (n=4), realistic evaluation (n=1), critical social theory (n=1), and field study (n=1). A wide range of data collection methods were included: observation, interviews, field notes, focus groups, compassion cafes, photo elicitation, stories, group discussion, workshops.

One large-scale research study is notable for raising the profile of compassionate care provision in healthcare, the Leadership in Compassionate Care Programme (LCCP) (Adamson *et al.,* 2011). This was a three-year research study involving, action research, relationship centred care, and appreciative inquiry. The research was conducted across inpatient facilities in NHS Lothian, Scotland, and therefore the results are not necessarily generalisable. The aim of the research was to "embed compassionate care as an integral aspect of all nursing practice and education'' (Adamson *et al.,* 2011, p.14). Four research strands were created, the establishment of Beacon Wards (centres of excellence within a hospital), developing leadership skills through facilitation, embedding relationship-centred compassionate practice into the undergraduate curriculum, and supporting newly qualified nurses. From this large-

scale study additional papers were published, seven of which have been included in the ILR. The papers presented research studies aimed at enhancing compassionate care in both practice and education (Dewar *et al.,* 2010; Dewar & MacKay, 2010; Horsburgh & Ross, 2013; Dewar and Cook, 2014; Smith *et al.,* 2014; Adamson and Dewar, 2015), and the creation of a conceptual model for compassionate relationship-centred care (Dewar & Nolan, 2013).

The quantitative studies

The quantitative studies (n=6) emanated from the following countries: USA (4), international studies (2). Quantitative design included descriptive studies (n=4).

The mixed method studies.

The mixed methods studies (n = 5) emanated from the UK. The designs incorporated varying data collection methods such as surveys, discourse analysis, observation, interviews, and focus groups.

The literature reviews.

The literature reviews (n=10) emanated from the following countries, UK (5), Canada (4), and Australia (1). All were focused on issues related to compassionate care giving that included perceptions and interventions for compassionate care (n=2), association of organisational and workplace cultures with patient outcomes (n=1), compassionate leadership (n=1), teaching and learning compassion (n=1), teaching and learning and measurement of compassion (n=1), measurement of compassion (n = 2); compassion fatigue (n=1), and self-compassion (n=1).

2.5.2 Synthesis of the study findings

A constant comparative analysis (CCA) (Lincoln and Guba, 1985) was undertaken across the research studies (n=37) and literature reviews (n=10). Data reduction and

display involved classifying the primary sources data, identifying patterns, themes, and relationships in the literature related to the provision and maintenance of compassionate care. Data comparison involved iteratively identifying and grouping similar variables to identify themes and relationships. The aim was to create an integrated analysis. Three overarching themes emerged, *Personal/relational issues, Organisational issues*, and *Educational issues*. Appendix 5 displays the primary source data, and variables and relationships associated to the overarching themes.

2.5.3 Overarching themes developed from synthesis of findings.

The overarching themes structure the discussion, and the subthemes are integrated, establishing what is already known, and any gaps in the literature, about compassionate care giving and, consequently, informing understanding and contributing to the construction of the aims and objectives of the research.

Personal/relational issues

Personal and relational factors impact on compassionate care. Facilitators have been recognised as personal attributes, experiences, and motivation (Christiansen *et al.,* 2015; Sinclair *et al.,* 2016d; Singh *et al.,* 2018; Babaei and Taleghani, 2019); personal systems of values and beliefs which included personal commitment (Adamson and Dewar, 2015; Christiansen *et al*., 2015; Sinclair *et al*., 2016c), the impact of family upbringing and family demands (Jones *et al.,* 2016), and altruistic motives (van der Cingel, 2011). Also, collaboration among different professions and with patients' relatives/carers is important in the provision of compassionate care (Badger and Royse, 2012; Dewar and Nolan, 2013; Kvangarsnes *et al.,* 2013).

From the studies explored, two frameworks (van der Cingel, 2011; Kneafsey *et al.,* 2015) and three models (Dewar and Nolan, 2013; Sinclair *et al.,* 2016c; Sinclair et al.

2018) were identified. These frameworks and models explored the attributes required of the nurse in relationship building related to compassionate care, focusing on the behaviours and actions of the nurse to the patient.

Van der Cingel (2011) explored the relationship between nurses and older people, developing a theoretical framework of compassion. The framework identified the nature of compassion as having seven dimensions demonstrated from nurse to patient; attentiveness, listening, confronting, involvement, helping, presence, and understanding. The theoretical framework consisted of five leading issues, compassion and suffering, compassion and identification, the emotion compassion, motives for compassion, and the moral significance of compassion. Kneafsey *et al.,* (2015) developed a framework for Compassionate Inter-Personal Relations from a study involving healthcare professionals and patients. The stages involved in relationship building were identified as connecting, recognising feelings, becoming motivated, taking action to help, and sustaining relationships. Compassion was viewed as an altruistic quality, the aim being to help another rather than achieve personal gain (Kneafsey *et al.,* 2015).

Dewar and Nolan (2013) developed a conceptual model to support staff in the delivery of compassionate relationship-centred care. Based on "appreciative caring conversations" that helped staff to gain personal and relational knowledge to enable collaborative working (p.1). Essential attributes were identified; being courageous, connecting emotionally, being curious, collaborating, considering other perspectives, compromising, and celebrating. Sinclair *et al.,* (2016c) conducted research focusing on the experiences of palliative cancer care patients and from this developed The Patient Compassion Model (PCM). The model consisted of seven categories. Compassion was predicated on the *virtues* of the healthcare provider, delivered in a

relational space involving patient awareness and engaged caregiving, requiring a *virtuous response*, knowing the person, prioritising the person, with the aim of *seeking to understand* the person and their needs*;* through *relational communicating,* actioned through *attending to needs;* and resulting in *patient reported outcomes* of alleviating suffering and enhancing wellbeing. Sinclair *et al.,* (2018) extended previous research (Sinclair *et. al.,* 2016c) to create a Healthcare Provider Compassion Model (HPCM) to guide clinical practice. Participants in the research were HCPs identified as exemplary compassionate care providers. They conceptualised compassion as a virtuous and intentional response – knowing a person in order to discern their needs and ameliorate their suffering through relational understanding and action. Sinclair *et al.,* (2016d) and Bramley and Matiti (2014) suggest inherent qualities and moral virtues are significant mediators of compassionate care.

The two frameworks and three models focused on the behaviours and actions of the nurse to the patient. There is an absence of recognition within the communicative activity between the nurse and patient that both give and receive reciprocally. The vulnerability of the patient was recognised in communication and caregiving, but not that of the nurse. Also, the frameworks and models were developed in specific specialisms of care, consequently challenging generalisability.

Both verbal and nonverbal communication have been identified as integral to the provision of compassionate care (Perry, 2009; Badger and Royse, 2012; Dewar and Nolan, 2013; Horsburgh and Ross, 2013; Kneafsey *et al.,* 2015; Sinclair *et al.,* 2016c). Associated behaviours include smiling, appropriate touch, and eye contact (Fry *et al.,* 2013; Kneafsey *et al.,* 2015), acting with warmth, empathy (Bray *et al.,* 2014; Sinclair *et al.,* 2016c; Durkin, Gurbutt and Carson, 2018), genuineness, and kindness (Kneafsey *et al.,* 2015) and attentiveness (van der Cingel, 2011; Bramley and Matiti,

2014; Way and Tracy, 2012). Also, humour has been found to be a way that nurses connect with patients (Burnell and Agan, 2013; Dewar and Nolan, 2013). These behaviours and actions support communication and build trust. Providing quiet and space contributes to effective communication (Way and Tracy, 2012; Jones *et al.,* 2016) and supports the provision of sensitive information (Way and Tracy, 2012; Kvangarsnes *et al.,* 2013; Bramley and Matiti, 2014; Kneafsey *et al.,* 2015). Overall, effective communication enables the elicitation of emotional disclosure over time (Perry, 2009).

Research has identified that relationship building includes getting to know the patient, feeling the patient's suffering, identifying with and linking with patients, demonstrating respect, and willingness to provide support to meet individualised needs (Sumner, 2008b; Graber and Mitcham, 2004; Badger and Royse, 2012; Kvangarsnes *et al.,* 2013). To offer an analogy, practitioners need to be able to put themselves in the 'shoes of the patient,' to understand how they feel (van der Cingel, 2011; Dewar and Nolan, 2013; Bramley and Matiti, 2014). Sinclair *et al.,* (2016d, p.446) suggest this requires a move from "feeling with" (empathy) to "feeling for" another, a distinguishing feature of compassion. From these studies it is recognised that compassionate relationship building requires the nurse to engage with the feelings and experiences of the patient. Sinclair *et al.,* (2016c) suggests the relationship is augmented by the caregivers' virtues, intuition, affect, and presence.

When providing care with compassion the focus has been on responding to suffering. However, providing compassion also gives comfort and can be conveyed in small acts, gestures or attending to the 'little things,' (Sumner, 2008b; Perry, 2009; Dewar and Nolan, 2013; Bramley and Matiti, 2014). Sumner (2008b) suggests these behaviours

are unconsciously altruistic, going above and beyond to meet the patient's needs (van der Cingel, 2011; Bramley and Matiti, 2014; Kneafsey *et al.,* 2015).

Compassionate communication has been identified as a willingness to engage with and be affected by patients and their experiences, and as the nurse absorbs uncomfortable feelings this results in vulnerability (Sumner, 2006; Way and Tracy, 2012; Kvangarsnes *et al.,* 2013; Strauss *et al.,* 2016). This is a recognition of investment by the nurse in the nurse-patient relationship and is worthy of further investigation, seeking to understand the promoters and inhibitors impacting on the relationship and the associated investment of both nurse and patient.

Research has identified increased job satisfaction and improved recruitment and retention in nursing as associated benefits of relationship building and creating emotional resonance with the patient (Graber and Mitcham, 2004; Perry, 2009; Burtson and Stichler, 2010; Way and Tracy, 2012). Relationship building benefits from nurses not distancing themselves from patients' emotions (Graber and Mitcham, 2004; Perry, 2009). However, challenges to this exist. Dislike, difficulty in creating a rapport, or personal prejudices towards individual patients have been identified as inhibitors of compassionate communication (Christiansen *et al.,* 2015; de Zulueta, 2016; Singh *et al.,* 2018). This may, for example, occur if a patient is rude or overly demanding (Sumner, 2008b; Singh *et al.,* 2018) or there is confrontational behaviour from relatives (Christiansen *et al.,* 2015; Jones *et al.,* 2016).

Jones *et al.,* (2016 p.3143) found in their research, that "outside-the-workplace" factors, including the nurses' social and family situations and accompanying support, can create additional stress and impact negatively on the nurses' ability to be compassionate. The cultural backgrounds of nurse and patient have also been found

to impact on nurse-patient interaction (Papadopoulos *et al.,* 2016a, 2016b; Babaei and Taleghani, 2019). In hospital situations the gender of the nurse, the restrictions this may place on care giving, and sometimes the lack of shared language, can present sociocultural barriers (Babaei and Taleghani, 2019). As Papadopoulos *et al.,* (2016a) and Babaei and Taleghani (2019) recommend that compassionate care giving must include culturally appropriate approaches, the impact of personal issues and cultural influences are worthy of further exploration.

In summary, the importance of building a compassionate relationship with the patient has been explored and this requires a range of behaviours, skills and actions from the nurse. However, the investment of nurses and their resulting vulnerabilities, combined with the impact of their experiences on the compassionate relationship require further investigation.

It is evident that the delivery of compassionate care is influenced by the context in which compassionate care is provided. Therefore, organisational issues impacting on compassionate care giving will now be discussed.

Organisational issues

Organisations have their own cultures and subcultures, with shared values, assumptions, and beliefs within occupational groups (de Zulueta, 2016). In a systematic review, Braithwaite *et al.,* (2017) found linkage between positive organisational and workplace cultures and improved patient outcomes e.g., reduced mortality rates, falls, and hospital acquired infections and increased patient satisfaction. Organisational culture can also impact negatively on the provision of compassionate care (Bramley and Matiti, 2014; Christiansen *et al.,* 2015; Jones *et al.,* 2016; Singh *et al.,* 2018; Babaei and Taleghani, 2019). This can result from culture

and system constraints focusing on efficiency, financial savings, and meeting targets (de Zulueta, 2016; Sinclair *et al.,* 2016a) impacting negatively on the behaviour of staff and resulting in uncompassionate care (Sumner, 2008b; Horsburgh and Ross, 2013; Bramley and Matiti, 2014).

Dixon-Woods *et al.,* (2014) conducted a large mixed methods research study to examine culture and behaviour in the NHS. Data was collected from multiple sources, including executive and board level staff and frontline clinicians. The findings identified that consistent achievement of high-quality care was challenged by unclear goals, overlapping priorities, and a compliance–oriented, bureaucratised management. Dixon-Woods *et al.,* (2014, p.114) concluded that it is essential "to work continually to improve organisational systems and to nurture the core values of compassion". They found that strategies for creating positive cultures must include promoting staff health and wellbeing, listening and providing feedback to staff, modelling excellent teamwork, and ensuring staff feel safe, supported, respected and valued at work. These strategies must be supported by effective systems, positive leadership, support, and adequate staffing levels. Crawford *et al.,* (2013) and MacArthur *et al.,* (2017) suggested this must also be reflected in a person-centred approach to patient care.

MacArthur *et al.,* (2017) evaluated the impact of the LCCP (Adamson *et al.,* 2011), and used their research to develop a conceptual model of factors that enhance organisational capacity to develop and sustain a culture of compassionate care. MacArthur *et al.,* (2017) identified the significant impact of leadership on the culture of an organisation. Positive cultural change can result when senior management visibly reflects organisational values and vision in their actions, engaging front-line staff, providing necessary resources and establishing accountability for performance. Hunsaker *et al.,* (2015) suggest positive communication and support from managers

engender higher levels of compassion satisfaction and lower levels of burnout in nursing staff. However, international research by Papadopoulos *et al.,* (2016a, 2016b), identified that nurses received little compassion from management.

Organisational culture impacts on compassionate care, but organisational systems and the workplace environment can also create barriers. The latter include workload issues and lack of time and staff (Crawford *et al.,* 2013; Fry *et al.,* 2013; Bray *et al.,* 2014; Christiansen *et al.,* 2015; Sinclair *et al.,* 2016a; Singh *et al.,* 2018; Babaei and Taleghani, 2019) and increased paperwork with a focus on metrics and efficiency (Sinclair *et al.,* 2016a). Such barriers can result in nurses' lack of motivation and exhaustion and a focus on routines instead of patients (Babaei and Taleghani, 2019). This challenges their ability to meet professional standards, and demonstrate professional competence and confidence (Badger and Royse, 2012; Kvangarsnes et al 2013; Bray *et al.,* 2014). Research by Curtis, Horton and Smith (2012) and Curtis (2013) identified that nurses felt vulnerable because of constraints outside their control which created dissonance between professional ideals and practice reality.

If the aim is to embed compassionate care into organisational learning, development, and governance processes (Dewar and Nolan, 2013; Dewar and Cook, 2014), the effectiveness of interventions and measures must be evaluated (Sinclair *et al.,* 2017a). Systematic literature reviews have identified notable psychometric weaknesses and a lack of methodological rigour in measures of compassion (Blomberg *et al.,* 2016; Strauss *et al.,* 2016; Sinclair *et al.,* 2017a; Durkin, Gurbutt and Carson, 2018). Intervention description was generally weak, there was lack of detail relating to participants and facilitators, and proposed strategies for change were often unclear (Blomberg *et al.,* 2016). An example of this is The Compassionate Care Assessment Tool (CCAT) created by Burnell and Agan (2013). The tool was completed by patients

with the aim of measuring demonstrations of compassion by carers. However, Burnell and Agan's analysis indicates that patients rated how important each item was to them, rather than the extent to which their carers exhibited compassion. This means that it is not clear whether the scale is measuring actual levels of compassion.

Blomberg *et al.,* (2016) and Sinclair *et al.,* (2016b) also concluded that the most common type of intervention focused on training nursing staff, despite evidence that the most significant barriers are related to both the practice setting and the organisation. Sinclair *et al.,* (2016b) also identified concerns from patients that a formulaic approach, based on the measurement of actions and gestures, may result in less authenticity, undermining the composite nature of compassion and impacting on both the experience of patients and the satisfaction derived by nurses (Sinclair *et al.,* 2016b). Nevertheless, calls for further research to define, delineate, and measure the construct continue (Blomberg *et al.,* 2016; Strauss *et al.,* 2016; Sinclair *et al.,* 2017a; Durkin, Gurbutt and Carson, 2018).

Research has identified that support for staff, valuing the role of relationships, and investing in practice development and leadership at all levels, sustain the delivery of compassionate care (MacArthur *et al.,* 2017). Good leadership is considered pivotal for enabling the development and preservation of compassionate organisations. de Zulueta (2016) suggests that theories depicting leadership as a collection of individual traits or characteristics, actioned through hierarchical command and control, are inappropriate. Collective and distributive leadership is more appropriate as "leaders and followers are mutually dependent and dynamically intertwined" (de Zulueta 2016, p.5). de Zulueta (2016) emphasised the importance of fostering leaders who embody and enact the qualities of compassionate leadership – altruism, integrity, humility, and wisdom combined with appreciation and empowerment of others. Dewar and Cook

(2014) developed a leadership programme that incorporated supported reflection on compassionate practices and resulted in enhanced self-awareness of leaders. Nonetheless, de Zulueta (2016) emphasised that holistic learning strategies must be combined with high levels of staff support and engagement to develop effective organisations. The conclusion is that leadership programmes are required to develop compassionate leadership, and support compassionate care giving.

Clinical placements, mentorship and role models in practice have a significant influence on the development of compassionate care skills (Curtis, 2013; Dewar and Nolan, 2013; Bray *et al.,* 2014; Christiansen *et al.,* 2015; Jones *et al.,* 2016; Sinclair *et al.,* 2016a). Despite this evidence, Horsburgh and Ross (2013) reported that, rather than receiving structured support, in practice student nurses found support was dependent on the goodwill of staff. In the reality of practice, students witnessed qualified nurses delegating caring activities to support staff, reducing engagement with, and understanding of, the patients' experience (Curtis, Horton and Smith, 2012). Furthermore, Horsburgh and Ross (2013) found reluctance to respond to new ideas in existing staff due to their entrenched views and resistance to change. Student nurses manage this dissonance between professional ideals and the reality of practice by balancing and adapting their ideals to conform to constraints (Curtis, Horton and Smith, 2012). A range of studies emphasise the need to provide support during and beyond the transition to qualified nurse (Dewar and Mackay, 2010; Horsburgh and Ross, 2013; Hunsaker *et al.,* 2015).

Research suggests that compassion is inherently reciprocal, happening within and between people, and experiencing compassion makes people better able to show compassion to others (de Zulueta, 2016; Papadopoulos *et al.,* 2016a, 2016b). Consequently, supportive, collaborative teams act as enablers to compassionate care

(Dewar and Nolan, 2013; Horsburgh and Ross, 2013; Hunsaker *et al.,* 2015; Christiansen *et al.,* 2015; de Zulueta, 2016; Jones *et al.,* 2016; Singh *et al.,* 2018; Babaei and Taleghani, 2019). Positive team working includes good team relationships, attending to the wellbeing of the team, and a collective team identity (Christiansen *et al.,* 2015).

When nurses do not receive appropriate support, they experience stress and are unable to engage in positive interpersonal relationship building (Fry *et al.,* 2013; Hunsaker *et al.,* 2015; Sinclair *et al.,* 2017b). Stress negatively impacts on the physical, emotional, social, and spiritual health of nurses (Burtson and Stichler, 2010; Hunsaker *et al.,* 2015; Sinclair *et al.,* 2017b). This can result in compassion fatigue and is correlated with burnout (Burtson and Stichler, 2010; Hunsaker *et al.,* 2015). Hunsaker *et al.,* (2015 p.191) identified that "increased years in the profession, more years in [practice], a higher level of educational background, shorter shift length and adequate manager support", positively influence the prevalence of compassion satisfaction, consequently reducing compassion fatigue and burnout. They concluded that improving recognition and awareness of compassion satisfaction, compassion fatigue, and burnout in nurses may prevent emotional exhaustion. De Zulueta (2016) also suggested clinicians need to be proficient in emotional regulation skills and adaptive strategies to cope. Fostering nurses' internal motivation may increase the frequency of caring behaviours (Burtson and Stichler, 2010). The type, and impact, of support received by nurses is worthy of exploration.

Being compassionate to others necessarily requires compassion for oneself (Sumner, 2008a; Dewar and Christley, 2013). The systematic review by Sinclair *et al.,* (2017a) suggests that engaging in self-care strategies (demonstrating self-compassion) sustains the wellbeing of nurses. Self-compassion includes being kind and

understanding towards oneself, having increased awareness of one's own negative thoughts, avoiding self-criticism, and practising self-acceptance (Sinclair 2017c).

A supportive environment, and the value leaders and managers associate with compassionate care have been found to be important in the provision of compassionate care (Fry *et al.,* 2013; Horsburgh and Ross, 2013; Dixon-Woods *et al.,* 2014; Christiansen *et al.,* 2015; Singh *et al.,* 2018). It is evident that compassion fatigue and burnout will continue to grow unless further strategies and solutions are made available to reduce the impact of pressures within the workplace (Hunsaker *et al.,* 2015). These include support mechanisms for existing staff (Curtis, Horton and Smith, 2012; Dewar and Nolan, 2013; Dewar and Cook, 2014; Papadopoulos *et al.,* 2016a, 2016b); collaborative team working (Christiansen *et al.,* 2015; Jones *et al.,* 2016; Singh *et al.,* 2018); and recognition that compassionate care requires high levels of skill and ongoing training (Dewar *et al.,* 2010; Horsburgh and Ross, 2013).

In summary, literature has identified an increased focus on the provision of compassionate care against a continuing backdrop of ever-increasing work-based demands. Also, nurses are subject to personal and relational demands in clinical practice and, potentially, outside the workplace. This raises the question of how the organisational culture, the clinical environment, and collegial support impact on nurses' ability to provide compassionate care. In the current climate of healthcare, what strategies do nurses utilise to enable compassionate care.

Educational issues

Nurses learn from personal, university and practice experience, influenced by nurse academics, practice-based mentors, and by the environment in which nursing takes

place (Curtis, Horton and Smith, 2012; Curtis, 2013; Dewar and Nolan, 2013; Bray *et al.,* 2014; Christiansen *et al.,* 2015; Jones *et al.,* 2016; Sinclair *et al.,* 2016a).

Research suggests nurses do not feel prepared to provide compassionate care based on their educational experience (Horsburgh and Ross, 2013; Papadopoulos *et al.,* 2016b; Sinclair *et al.,* 2016b; Babaei and Taleghani, 2019). Worryingly, research has found that the caring behaviours of students diminish as they near completion of their university programmes (Bray *et al.,* 2014; Sinclair *et al*. 2016a, 2016b). This can be the result of a teaching environment that emphasises knowledge-based competencies, resulting in a theory–practice gap (Sinclair *et al.,* 2016a). Intellectual ability and technical skills may be valued more highly than caring and compassion (Bray *et al.,* 2014) or teachers present an idealised view of practice that does not reflect the reality (Horsburgh and Ross, 2013).

Curtis (2013) suggested that university ideals may be at odds with professional ideals, with increased value on corporate goals related to research output, recruitment, retention, and student satisfaction. It has been suggested that compassion as a concept is not easily found in nursing curricula (van der Cingel, 2014; Papadopoulos *et al.,* 2016a, 2016b), and there is little guidance on how to develop competencies in compassionate care (Sinclair *et al.,* 2016a, 2016b). Findings from the LCCP identified that nurse academics had little time and limited opportunities to reflect, prepare, and evaluate their role in nurturing the compassionate and caring attributes of student nurses (Adamson *et al.,* 2011). Nurse academics often faced dissonance in managing large student groups, with less time and opportunity for small group discussion, and in develop compassion in a meaningful and emotionally sustainable way (Curtis, 2013). Smith *et al.,* (2014) added that nurse academics struggled to align individual values with organisational vision and lacked influence in decision making. Smith *et al.,* (2014)

concluded that nurse academics' own experience could be enhanced through opportunities for reflection, continuous individual feedback, and additional sources of support.

Educational barriers to compassionate care in the practice area have been identified as:

- lack of support in practice by managers (Papadopoulos *et al.,* 2016a)
- time constraints that limit mentoring and group or self-reflective opportunities (Curtis 2013; Sinclair *et al.,* 2016b)
- poor quality of mentoring (Sinclair *et al.,* 2016b)
- reduced staffing and resources (Sinclair *et al.,* 2016b).

This results from an economically constrained and target driven practice reality (Curtis, 2013; Sinclair *et al.,* 2016b). The intention to provide compassionate care, faced with practice constraints, results in student nurses feeling vulnerable as they attempt to balance professional ideals and practice reality (Curtis, 2013; Curtis, Horton and Smith, 2012).

International research by Papadopoulos *et al.,* (2016a) found that the nurses' cultural backgrounds and their own experiences of receiving compassion, influenced the way they viewed and defined compassion. However, in this research a survey was used that offered a choice of only three definitions of compassion; 59.5% of participants selected *Deep awareness of the suffering of others and a wish to alleviate it*, 9.3% selected *Deep awareness of the suffering of others,* and 28.2% selected *Empathy and kindness,* while 3% selected *other.* The limited choice and the lack of explanation of the words 'deep' and 'suffering' were limitations of the research design. As previously suggested, compassion is not simply about relieving suffering but can be conveyed in

small acts and gestures (Perry, 2009; Von Dietze and Orb, 2000; Dewar, 2011; Dewar and Nolan, 2013; Bramley and Matiti, 2014; Durkin, Gurbutt and Carson, 2018). The Willis report (2012 p.35) on nursing education recognised that "Britain is a multicultural country and nurses must be able to provide clinically competent but also culturally competent and compassionate care." Papadopoulos *et al.,* (2016a) suggest that further research is required to understand the impact of cross-cultural differences and the impact of individual experiences.

If compassion is demanded it is crucial that the education process enables students to develop the skills, knowledge and attitudes required to deliver care with compassion (Horsburgh and Ross, 2013; Bramley and Matiti, 2014). The teachability of compassion is, however, the subject of ongoing debate. Research by Bray *et al.,* (2014) identified ambiguity in participant responses, with suggestions that compassion could be taught alongside statements that training was necessary to provide compassionate care. Much research acknowledges that compassion can be cultivated but it may be contingent on the innate human qualities that learners possess at baseline (Bramley and Matiti, 2014; Kneafsey *et al.,* 2015; Papadopoulos *et al.,* 2016a, 2016b; Sinclair *et al.,* 2016b, 2016d, 2018) that are "actualised through acknowledgement, engagement and action in response to patient suffering" (Sinclair *et al.,* 2016b p14). Consequently, for some it may be a natural disposition or intuition (van der Cingel, 2011), while for others it may slowly emerge through experience (Sinclair *et al.,* 2016a) and can be learned (van der Cingel, 2014).

Research has focused on approaches to enhance compassionate care in both practice and education (Dewar *et al.,* 2010; Dewar & MacKay, 2010; Dewar & Nolan, 2013; Horsburgh & Ross, 2013; Adamson and Dewar, 2015; Richardson, Percy and Hughes, 2015; Sinclair *et al.,* 2016d). Sinclair *et al.,* (2016d) found that patients were

unequivocal in identifying didactic, textbook, traditional competency-based approaches as not conducive to the development of compassion. However, an evidence-informed understanding involving education interventions to cultivate the necessary knowledge, skills and attitude is important. This must build on existing skills, developing compassion in care through methods that connect with practice (Curtis, Horton and Smith, 2012; Richardson, Percy and Hughes, 2015; Sinclair *et al.,* 2016a). It may be achieved through experiential learning approaches developing person-centred communication skills, reflective practice, and compassionate role modelling (Sinclair *et al.,* 2016a, 2016b).

The LCCP (Adamson *et al.,* 2011) includes research papers focused on approaches to enhancing compassionate care in both practice and education. Dewar and Mackay's (2010) research identified that being supportive and valuing relationships and reflection are pivotal to conveying compassion and could be taught and embedded into nursing programmes. Sinclair *et al.,* (2016d) concur, and add that cultivating compassion involves building a relationship, understanding the patient as a human being, and developing a connection (emotional resonance). Richardson, Percy and Hughes (2015) conducted a literature review on the development of caring, compassion and empathy in student nurses. This resulted in the design and implementation of a unit of study using Muetzel's (1988) model as a framework for therapeutic relationship building. However, justification was not given as to why this model was selected rather than another. Nevertheless, the components of Muetzel's model incorporate partnership, and reciprocity which aligns with Sumner's (2008a) emphasis on the bi-directionality of the nurse-patient relationship. Richardson, Percy and Hughes (2015) identified that nurses benefit from the two-way relationship through collaboration, mutuality, congruence, reciprocal exchange and sharing of values and

beliefs. Dewar *et al.,* (2010) focused on emotional touchpoints – key points in the patient journey – which were found to contribute to the development of effective and meaningful relationships between nurse and patient. Dewar and Mackay (2010) developed positive caring practice statements from which action plans were developed to enhance compassionate care. Dewar and Nolan (2013) focused research on the development of appreciative caring conversations enabling collaboration between patients, carers, and staff to support emotional engagement in practice. Adamson and Dewar (2015) used stories gathered within clinical practice to stimulate reflective learning as part of a nursing module. Students listened to experiences of giving and receiving care and the research found that this approach can develop knowledge, skills and confidence in student nurses, enabling provision of relationship centred care.

Opportunities to realise compassionate care could be increased through recruitment and selection strategies that encompass recognition of existing skills and experience (Kneafsey *et al.,* 2015; Durkin, Gurbutt and Carson, 2018). Durkin, Gurbutt and Carson (2018, p.57) propose a compassion scale could contribute to selection process for nursing. This could involve both nurse academics and qualified nurses, jointly assessing the interviewees' understanding and experiences of compassion. Subsequently, following selection, this understanding could be further developed in relation to compassionate care giving in accordance with their own unique learning styles.

In summary, nurses learn within the education system and the practice environment, however, it has been identified that they can struggle when attempting to balance professional ideals with the reality of practice. Exploring the views of nurses related to their understanding of the development of compassion and how education and practice have contributed can illuminate future curriculum design and implementation.

2.6 Stage 5 – Interpretation and presentation of results

The ILR has set the context for this research since compassionate care is something that the public, professional guidelines, and organisations recognise as integral to quality. The nature of compassion, and subsequently compassionate care, is established as a bi-directional activity between nurse and patient, with both bringing their lifelong experiences, values, beliefs, and expectations to the social interaction. It is associated with identifying actions, however small, which can give comfort and alleviate suffering and distress. Nonetheless, the personal demands on nurses to create meaningful relationships through which compassionate care can be realised require recognition of the emotional endeavour and feelings of vulnerability that result. There are benefits to nurses from the positive impact of providing care with compassion, but they are required to deliver this under challenging interpersonal conditions, regulating their own emotional reactions in practice. The experiences of student nurses, and their transition to becoming qualified nurses, reveals the impact of both the clinical environment and the process of socialisation in practice. As we recruit and prepare the future nursing workforce to provide compassionate care we must understand and respond to the challenges they face.

Communication and relationship building are integral to the development of compassionate care. This is achieved through recognising the shared investment of both nurse and patient. Frameworks and models have been explored that focus on relationship building (van der Cingel, 2011; Dewar and Nolan, 2013; Kneafsey *et al.,* 2015; Sinclair *et al.,* 2016c; Sinclair *et al.,* 2018). Nevertheless, none of these recognise the bi-directional nature of the activity and consequent vulnerability of both nurse and patient. Factors that impact on the nurse in relationship building and result in increased vulnerability are worthy of exploration.

The importance of a supportive organisational culture that values compassionate care has been evidenced. Managers and leaders must be visible and engaged with nursing staff, providing support and necessary resources (Dixon-Woods *et al.,* 2014; de Zulueta, 2016; MacArthur *et al.,* 2017). Role modelling by leaders and their encouragement for others to engage in compassionate care are important. Improved patient outcomes have been associated with better staffing ratios of patients to nurses, nurse involvement in decision making, and positive team relations (Dixon-Woods *et al.,* 2014; de Zulueta, 2016; Sinclair *et al.,* 2016c; Braithwaite *et al.,* 2017). This raises the question of how, in the current healthcare climate, the organisational culture, the clinical environment, and collegial support collectively impact on nurses' ability to provide compassionate care. Attempts to measure and evaluate interventions for compassionate care may result in a formulaic approach and be problematic when considering the multifaceted nature of compassion.

The complex features of both the practice and the educational environment in the teaching and learning of compassion have been explored. Discussion has identified an ongoing debate as to whether compassion is innate or can be developed. Additional research would enhance understanding of the relationship between the existing and ongoing experiences of nurses and compassionate care giving.

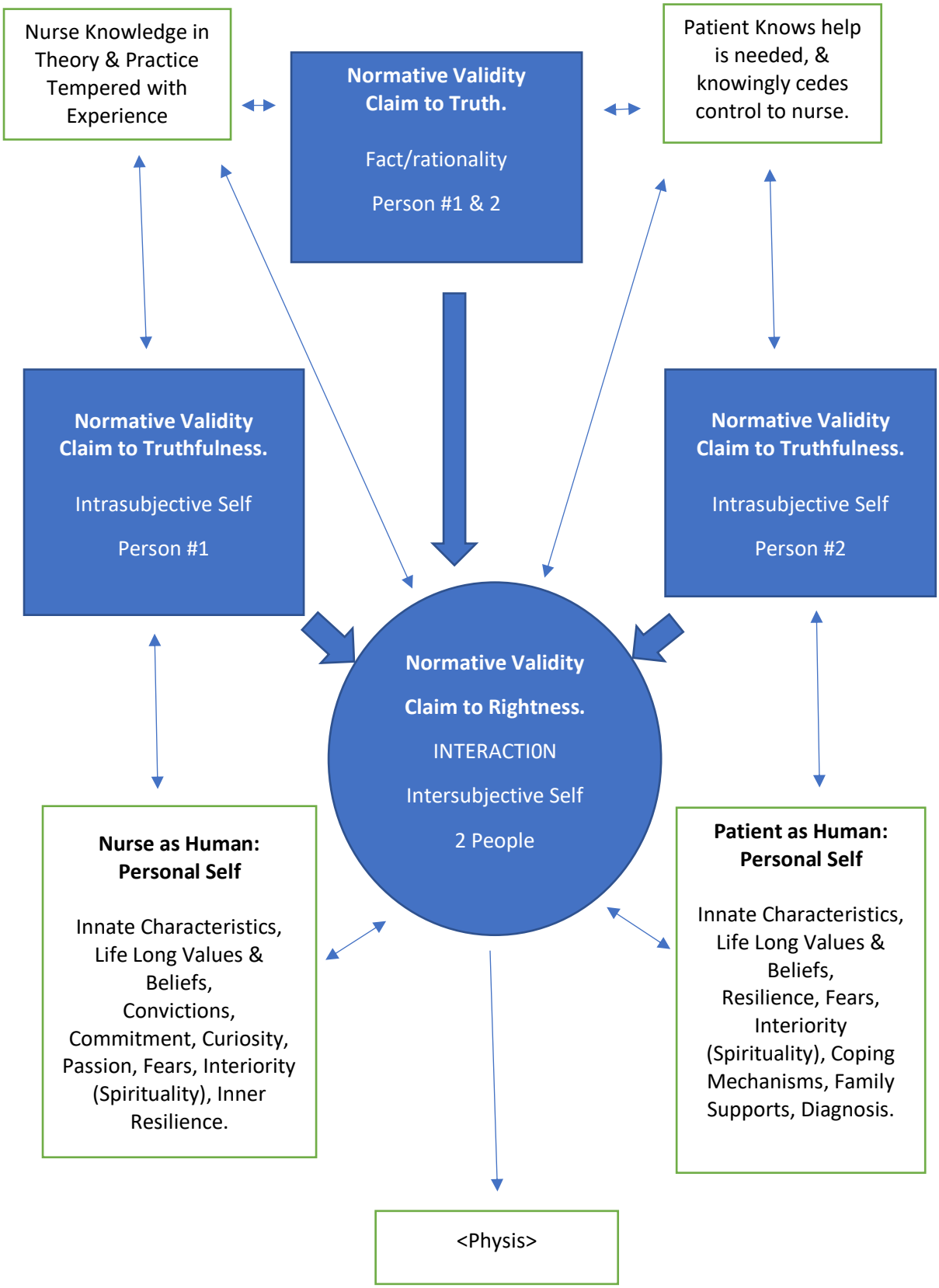
Established theory contributes to explanation and understanding of phenomena. The MCCNCAT (Sumner, 2008a) was selected as the theoretical framework for this research as it recognises the complexity and interconnectedness of caring in nursing. A central construct is the bi-directionality of communication between nurse and patient, characterised by care and compassion. A more detailed insight and justification for the application of the MCCNCAT (Sumner 2008a) will now be given.

2.6.1 Rationale for choice of Sumner's Moral Construct of Caring in Nursing as Communicative Action theory (MCCNCAT) as the theoretical framework

The MCCNCAT (Sumner 2008a) proposed that nurse and patient are equals, and the behaviours and actions of each affect the other, as well as the bi-directional communication between them. In the creation of the MCCNCAT, Sumner (2001, 2006, 2008a, 2008b) reinterpreted Habermas' (1995) Theory of Communicative Action and Moral Consciousness (TCAMC), which recognised that individuals can only mature through the socialisation arising from communication. Habermas (1995) proposed that communication exposes all humans, makes them vulnerable and should be negotiated rather than coercive. Accordingly, for the discourse to be moral "considerateness" towards each other is required (Habermas, 1995, p.198). Habermas' (1995) TCAMC encompassed three claims to normative validity in communication that arise from a "universe of norms" (Habermas, 1995, p.161). These are dependent "upon the continual reestablishment of legitimately ordered personal relationships" (p.61). The three claims are the claim to truth (which is factual, objective knowledge); the claim to truthfulness (which refers to the intrasubjective self and includes lifelong values and beliefs); and the claim to right (the intersubjective interaction or discourse between two individuals).

Based on Habermas' theory, Sumner (2008a) recognised that bi-directional communication affects both nurse and patient, as both are exposed and therefore vulnerable, requiring 'considerateness' towards each other and to self. This reinterpretation resulted in new understanding of the nurse-patient relationship, which Sumner (2008a, p.41) stated "is caring in nursing". Figure 2 shows the structure of the MCCNCAT.

Figure 2 – Sumner (2008 p260) The Moral Construct of Caring in Nursing as Communicative Action (MCCNCAT). “In the ideal communicative relationship both nurse and patient are equal participants; the Nurse’s personal self and professional self and the patient’s personal self and illness self are engaged in discourse with an outcome of <physis> or validation.”



Sumner (2006, p.9) framed each interaction between nurse and patient as having two components:

- The first being, the 'personal self', relating to both nurse and patient and is both intrasubjective and intersubjective including all aspects of the individual. This includes personality traits, physical characteristics, different social roles, sense of identity, feelings, and inherent obligation to self. An individual's perceptions of these needs are influenced by lifelong values, beliefs, and experiences. The personal self of the nurse and patient falls within Habermas' normative claim to truthfulness and the normative claim of rightness.
    - The nurse also has a 'professional self', including theoretical, practical, and experiential knowledge, overlaid with the values of the nursing profession with elements of duty and obligation. This nursing knowledge falls within the normative claim to truth.
- The second component being the 'illness self of the patient' which is influenced by their internal coping mechanisms, the severity of their illness, and the effectiveness of family support systems. Patients come to the nurse-patient interaction with a normative claim to truthfulness.

Sumner (2006) proposed that verbal and non-verbal communication encompasses the personal self and the professional self of the nurse, and the illness self of the patient. It is this communicative relationship that gives rise to the obligations, receptiveness, responsiveness, responsibilities, accountability, and answerability of each to the other. Sumner (2008a) said the nurse-patient relationship has cognitive, emotional, and attitudinal elements which both nurse and patient will use to come to an agreement on an accepted course of action. The moral object of the relationship will be the patient's health, as seen through the prism of human vulnerability. Sumner (2008a, p.42)

suggested that “the temporary power of compassion utilized by the nurse, along with the patient’s own efforts ensures this goal can be reached”. Both nurse and patient are “involved for an outcome, which is mutually rewarding and leads to validation and blossoming” (Sumner, 2006, p.11) or “<physis> ergo caring in nursing” (Sumner 2008a, p.41). Sumner (2008a) proposed that nursing is a moral, bi-directional activity between nurse and patient which is characterised by care and compassion.

Accordingly, applying the MCCNCAT as the theoretical framework to this research will provide the foundation on which to build insight and understanding of the nurse-patient relationship within which compassionate care is provided.

To demonstrate the connection between the aim of this research, findings from the ILR and the theoretical framework, an interpretation of compassionate care has been developed:

> *Compassionate care is a complex, interconnected, multidimensional concept, involving cognitive, behavioural, and affective dimensions, in which emotion and reason are intertwined. The aim of compassionate care is to provide comfort and alleviate suffering and distress. The bi-directional nature of the compassionate relationship involves inherent responsibilities, as the vulnerability of both the nurse and patient is exposed. Accordingly, both require support and considerateness to achieve fulfilment and satisfaction, leading to validation and growth.*

This interpretation reflects the nature of compassion, the components of the MCCNCAT (Sumner 2008a), and the aim of compassionate care. The focus of this research is to explore factors that impact on, and sustain, the provision of compassionate care in nursing. From this, the support required will be identified.

Overall, the ILR has illuminated existing literature within the overarching themes of, personal/relational issues, organisational issues, and educational issues, that influences the provision of compassionate care. It is evident that further research is required to understand how compassion is expressed and shaped in nursing practice and to investigate the strategies nurses use to achieve compassionate care in the current social, political, and economic context. This will support understanding of how the individual nurse can be supported by their organisation, practice, and education to better prepare them to respond to these challenges.

The aim of this research is to investigate nurses' views on compassionate care, and research questions evolved from the literature and the theoretical framework.

1. What are the views of nurses about compassionate care?
2. For nurses, what factors promote compassionate care?
3. For nurses, what factors inhibit compassionate care?
4. How do nurses achieve and maintain compassionate care?

2.7 Summary

The ILR connected existing knowledge to the problem under investigation and the theoretical framework offered explanation of phenomena and relationships associated with the subject topic. The next step was to decide upon a methodology that supported the researcher's position as an interpretive qualitative researcher and guided the research design. As this investigation explores a subjective and complex concept, a robust and rigorous methodology was required.

In the next chapter a rationale for the choice of methodology will be discussed followed by the process of operationalisation.

Chapter Three – Methodology

3.1 Introduction

Chapter Two explored existing research related to compassion and compassionate care in nursing and identified gaps in understanding. Based on that literature, the aim and research questions for this research have been identified. This chapter will discuss and justify the methodology that underpinned the research design, its application and operationalisation.

3.2 Positioning myself as a researcher

My research adopted interpretivist and holistic approaches, reflecting my epistemological position and viewing the world through the perceptions and experiences of participants taking an *insider* (emic) perspective (Watson *et al.,* 2008). Interpretivism is linked to the epistemology of subjectivism and the belief that the world does not exist independently of our knowledge of it (Grix, 2004, p.83), with multiple and complex realities that are socially constructed (Guba and Lincoln, 1982; Cohen, Manion and Morrison, 2007). Burton and Bartlett (1999) suggest that the interpretivist paradigm proposes that norms and values exist only as shifting organic elements of social life, used and changed by people as they interpret and respond to events. In searching for meaning, interpretivist researchers look beyond an individual's actions and engage with the participants' positions in the social world. The researcher acts as a listener and interpreter of the data from the participant, operating on the premise that total detachment is unattainable (Giddings and Grant, 2006). Interpretive research does not attempt to find patterns of similarities amongst the masses; instead, it looks for both similarities and differences within the collection of participants (Burton and Bartlett 2009).

3.3 Justification for choice of methodology

Q methodology is an integrated research approach that synthesises quantitative and qualitative methods, enabling the conversion of subjective perspectives into an objective outcome (Akhtar-Danesh, Baumann and Cordingley, 2008; Watts and Stenner, 2005). William Stephenson (1953) developed Q methodology, aimed at the scientific investigation of subjectivity. He was concerned about the dominant positivist hypothetico-deductive methods used in psychology, emphasising the need for curiosity, "making discoveries rather than testing our reasoning" (Stephenson, 1953, p.151). Stephenson argued that there was a need to allow for subjectivity within research, whereby participants could conduct measurements instead of being subjected to measurement (Brown, 1994-1995). Stephenson (1935, p.19) suggested, "In contrast to standard quasi-quantitative techniques in which individuals are scored by tests, in Q methodology the tests get the scores instead, due to the operation of the individuals upon them."

Central to Q methodology, is the concourse theory of communication (Stephenson, 1978, 1986). A concourse represents the volume of communication surrounding a topic, a universe of viewpoints for any context or situation (Brown, 1980). Subjectivity becomes evident when individuals communicate their thinking, thoughts, beliefs, values, and opinions about a phenomenon of interest (Stephenson, 1953; Brown, 1980) and is understood relative to its impact upon the immediate environment (Watts and Stenner, 2012). This is achieved by representing the concourse in a set of statements (Q sort). Participants are then required to sort the statements along a continuum of preference and the resulting data is analysed and interpreted. In a science of subjectivity, what matters is not what the statements are asserted to mean a priori, suggesting objectivity, but what subjective meanings the participants project

onto them during the Q sorting process (Brown, 2019). As suggested by Brown, (2006) and Midgley and Delprato (2017), subjectivity is natural behaviour and Q methodology is its natural science. Consequently, Q methodology is not just a method, it is a methodology comprised of procedures and a conceptual framework that provide the basis for a science of subjectivity (Brown, 1993).

Q methodology was selected as it fulfilled the aim of investigating human subjectivities within an interpretive design (Jeffares and Skelcher, 2011). Q methodology allowed nurse participants the freedom to express their positions, combining quantitative and qualitative data and analytical techniques, and providing numerical results to support interpreted perspectives. In the integrative literature review (ILR), both compassion and compassionate care were identified as complex, interconnected and multidimensional. Q methodology provided access to the diverse and multiple discourses on the subject topic (Curt 1994), offering a framework to explore subjective viewpoints in how nurses thought about compassionate care and how they related information from the external world to themselves. It also offered the opportunity to uncover how different but related topics were interconnected by requiring participants to consider diverse topics simultaneously. For example, Q methodology allowed participants to consider concurrently the three overarching themes that evolved from the ILR, (personal/relational issues, organisational issues, and educational issues). Participants (P set) were presented with statements about compassionate care in nursing (Q set) developed from the three overarching themes in the ILR. Practically, each participant sorted the Q statements, engaging in internal dialogue with themselves; the completed Q sorts were then correlated by-person, factored, and transformed into an operant factor structure. Q methodology yielded detailed statistical information that was interpreted qualitatively; I also employed additional

qualitative data collection methods. These included the use of a Report Sheet and a post Q sort interview to explore the rationale for participants decision making of the placing of the Q statements. A member of my doctoral supervisory team had developed and employed a Report Sheet in their own doctoral research (Brown, 2013) and gave permission for its modification and use within this research.

As Brown (1996) suggests, researchers can use Q methodology without having to set aside their principal approach or engage in a simplistic joining of quantitative and qualitative methods. The use of Q methodology, with further qualitative data collection methods, aligned with my position as an interpretive qualitative researcher. Using Q methodology supported the investigation of nurses' shared perspectives by gathering both quantitative and qualitative data from highly subjective viewpoints.

3.4 Q methodology and research in healthcare

I was aware of the growing interest in the application of Q methodology to nursing research for investigation of topics on which there is much debate and contestation (Akhtar-Danesh, Baumann and Cordingley, 2008). Q methodology had been found to be particularly valuable in research exploring human perceptions and interpersonal relationships (Dennis, 1986). Examples include: the meaning of health and illness (Dennis, 1986; Stainton Rogers, 1991); stress and coping strategies in community psychiatric nurses (Leary *et al.,* 1995); perceptions of professionalism among nurses (Akhtar-Danesh *et al.,* 2013); and attitudes toward clinical practice in undergraduate nursing students (Ha, 2015). However, Q methodology had not been used to investigate the views of nurses on compassionate care. This presented an opportunity to demonstrate the appropriateness, and value, of Q methodology to another issue in healthcare research.

3.5 Consideration of an alternative methodology

Alternative research methodologies were considered, e.g., a positivist or a phenomenological approach, but were rejected for reasons outlined in the discussion below.

A positivist approach could "be critiqued on the grounds that it fails to understand the multiplicity and complexity of the life world of individuals" (Scott and Usher, 2011, p.29). Also, the ontological position requires acceptance that there is only one truth, an objective reality that exists independent of human perception (Thompson, 1995). Within positivist paradigms it is suggested that researcher and participants are independent entities (Sale, Lohfeld and Brazil, 2002). The researcher can then study a phenomenon without influencing it or being influenced by it; "inquiry takes place as through a one-way mirror" (Guba and Lincoln, 1994, p.110). Although my aim was to minimise the impact of my own views, I could not completely erase the influence of my proximity to the research and background as a nurse.

Phenomenological approaches were considered. However, Mackey (2005, p.179) identified that nursing literature reflects concern about the adoption of phenomenological methods without "laying the philosophical and methodological foundations on which the method is built." Descriptive phenomenology suggests bracketing foreknowledge, through reflection that consciously sets aside previous knowledge detaching oneself from prejudices, prior understandings and one's own history. This has been critiqued as simplistic and unattainable (Spinelli, 2005). Interpretive phenomenology (IP) rejects suspending opinion in favour of interpretation of experiences through differing lenses and has been criticised as lacking standardisation and being mostly descriptive (Larkin, Watts and Clifton, 2006; Hefferon and Gil-Rodriguez, 2011). However, Feyaerts and Vanheule (2015) suggest

attempts to view subjectivity by reflecting upon it are unrealistic, as the essence of subjectivity disappears the moment it is looked upon as an object. This approach therefore risked capturing opinions rather than the meaning of lived experiences (Willig, 2013). Because the focus of my research was the study of subjectivity, I rejected phenomenology, which approaches "subjectivity reflectively, not as it is lived by the person living it… but as an object of observation, thereby transforming it" (Brown, 2019, p.577).

3.6 The concourse and Q sample development

The development of the concourse that was to reveal the subjective structure of the views around compassionate care in nursing was a critical step in this study. The concourse was developed from the ILR, meetings with my doctoral supervisory team, nurse academics, and focus group participation. Figure 3 shows the chronological order of Q sample construction, from populating the concourse to developing and evaluating the preliminary set of statements, and piloting the Q sample which resulted in the final set of Q statements (Q set). The process involved continually editing and refining the statements and was a 'craft' requiring a major investment of time (Curt, 1994, p.128), before proceeding to the Q study itself. Curt (1994) and Stainton Rogers (1995) recommend that between 40 and 80 statements are incorporated in the final Q set. Too few may result in inadequate coverage and too many may result in an unwieldy and demanding sorting process.

To represent the concourse, the Q set needs to be heterogenous while retaining some degree of homogeneity (Stephenson, 1953; Brown, 1980). Establishing the concourse can be undertaken in various ways, through analysis of academic, media and other texts (Dryzek and Berijikian, 1993), interviews with relevant participants (Steelman and Maguire, 1999), focus groups (Dryzek and Holmes, 2002), or a combination of these.

According to Stephenson (1952, p.223) a Q sample "may be designed purely on theoretical grounds, or from naturally-occurring (ecological) conditions, or as required for experimental purposes, to suit the particular requirements for an investigation". A theoretical approach aids exploration of theoretical perspectives related to the lived world of the Q sorters, while a naturalistic approach gathers statements from subjective viewpoints expressed, for example, in the media, everyday conversations, or interviews (Sæbjørnsen *et al.,* 2016). The aim of this research was not necessarily to establish the extent to which participants endorsed themes identified in the ILR, but rather that the concourse should provide a way of capturing the debate. I also wanted to include a naturalistic approach by involving a range of subjective experiences and knowledge from my doctoral supervisory team, nurse academics, and student nurses. Their contribution was originality, but it also offered evaluation of statements developed from a theoretical perspective. As suggested by Sæbjørnsen *et al.,* (2016), this combined approach benefits from advantages associated with both approaches.

I began by developing a concourse of 108 preliminary statements in the Q sample, drawn from academic literature, and from conducting constant comparative analysis (CCA) within the ILR. This involved classifying the primary sources data; data comparison involved iteratively identifying and grouping similar variables to categorise themes and relationships. From this process themes and subthemes developed. The CCA revealed three overarching themes related to compassionate care in nursing: *Personal/relational Issues, Organisational Issues,* and *Educational Issues. Personal/relational Issues*, involved 18 clusters of variables that contributed to three subthemes: Interpersonal factors; Communication; and Relational factors.

Organisational Issues involved 23 clusters of variables that contributed to five sub themes: The Organisational culture; The influence of managers, leaders, and mentors;

The workplace environment; Measuring compassionate care; and Compassion satisfaction and compassion fatigue.

Educational Issues involved 13 clusters of variables that contributed to three subthemes: Learning in practice and university; Challenges to nurse teachers; and Teaching compassion.

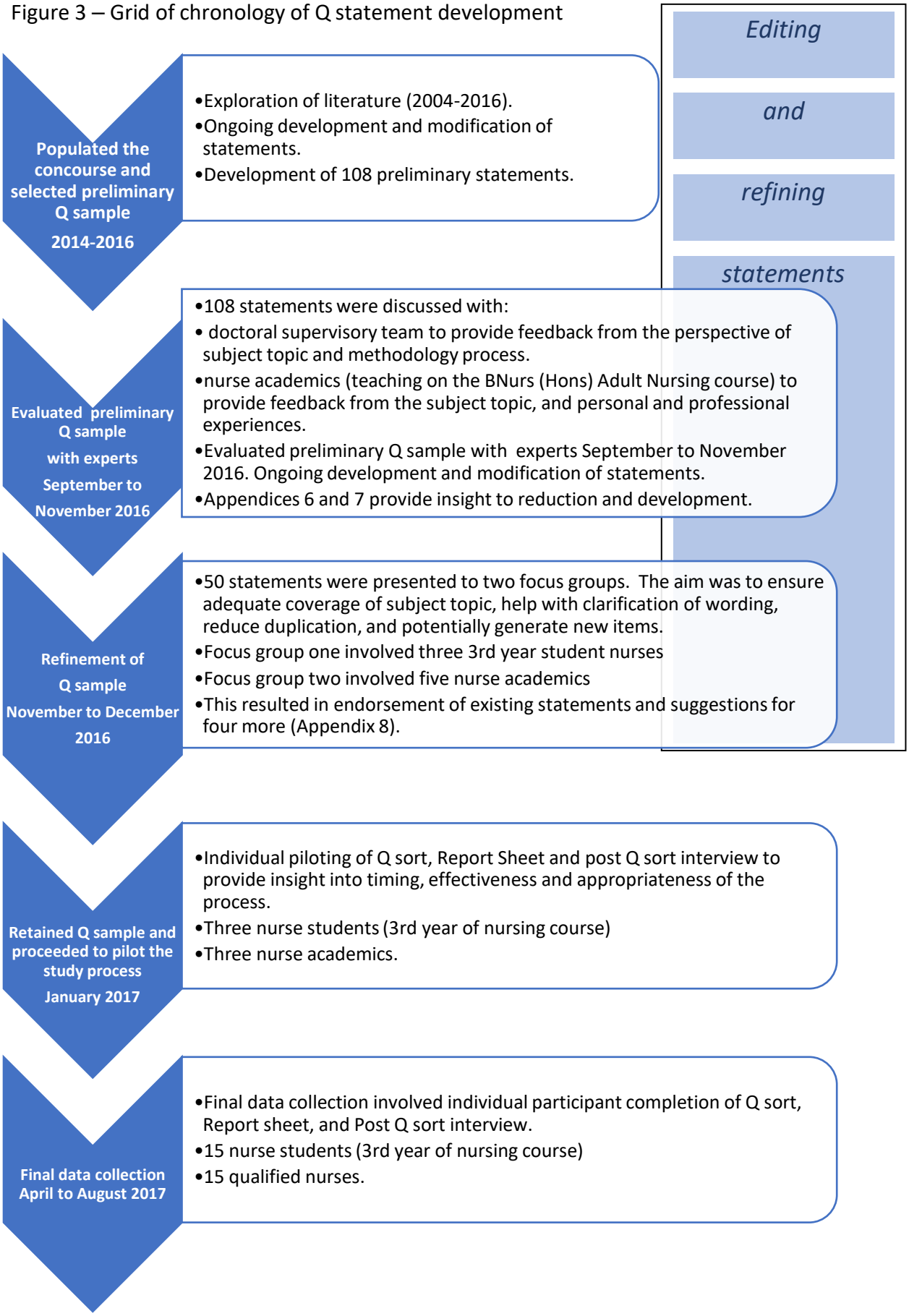
In total 3 overarching themes, 11 sub themes and 54 clusters of variables contributed to the Q statements. A more detailed insight to the grouping of variables/sub themes related to the overarching themes is presented in Appendix 5.

Applying the components of the MCCNCAT (Sumner, 2008a) alongside the three overarching themes and subthemes confirmed that the developing Q sample, acknowledged the role and impact of the nurse and patient through a bi-directional, communicative, and caring relationship (Appendix 6). Statements were generated relative to each theme with the aim that they could reflect participants' viewpoints and adequately represent the concourse of the research topic. Every statement was designed to stimulate self-reference, based on the psychological significance it had for the participant (Watts and Stenner, 2012). The final date for accessing the literature used to inform the concourse was September 2016 (Appendix 8). This captured the growth of interest in the topic of compassion and compassionate care in policy, practice and research resulting from government inquiries and highly influential reports. The main data collection commenced in 2017. The ILR continued to be updated until 2019, to ensure current literature was presented in the research. Appendix 8 reflects the literature contributing to the concourse up to September 2016, and the ongoing theme development in the ILR. Research within the later time span confirmed the existing focus of the Q statements.

From September to November 2016 the 108 statements were discussed within doctoral supervisory meetings, providing feedback from the perspective of the subject topic, and contributing expertise in Q sample statement construction. I also met, individually and collectively, with nurse academics who were specifically involved in teaching on modules about care provision in clinical practice. They were able to share their perspectives of the subject topic from their past and present experiences of working in clinical practice. By November 2016, the number of statements in the Q sample had been reduced to 50, and examples of the reduction process are shown in Appendix 7.

Refinement of the statements was conducted through a focus group approach (Figure 3). Feedback from the focus groups included revisiting the phraseology of eight of the existing statements and suggested adding four further statements. The content of the four statements focused on the limits to compassion, the influence of relatives on nursing practice, how equipped nurses feel when dealing with suffering and whether education enables uncompassionate care to be challenged (statements 51-54).

Figure 3 – Grid of chronology of Q statement development



Appendix 8 lists associated themes and references from the literature and Appendix 9 provides insight to the number of variables, sub themes, and themes that contributed to the final 54 statements.

3.7 Q methodology and the use of additional qualitative research methods

Eden, Donaldson and Walker (2005) suggest that Q methodology can also be complemented using additional qualitative research methods. I aimed to gather detailed qualitative data, post Q sort, to illuminate why participants placed statements in the extreme distribution columns (-5, -4, strongly disagree to +5, +4, strongly agree) and more neutrally. This would potentially reveal more detail about participants' decision-making processes and their views and experiences related to compassionate care giving. In taking this process forward, I was also mindful of Gallagher and Porock's (2010) suggestion that open-ended questionnaires and interviews serve to increase the richness and quality of the data collected.

Subsequently, I developed a Report Sheet to be used post Q sort (Appendix 10) structured to explore participant rationale for the placing of statements in extreme distribution columns. On the Report Sheet the participants were also asked to respond to the statement: *As you reflect on your responses to the 'card sort' it would be really helpful if you could identify how you believe nurses maintain compassionate care……..*

Following completion of the Report Sheet I planned to conduct post Q sort semi structured interviews that would make explicit participants' understanding of the statements and minimise errors of interpretation. Consequently, the factors were analysed in the context of participants' rationales; the rigour of the findings thereby increased and the aims of Q methodology – to explore individual meaning and subjectivity (Gallagher and Porock, 2010) – were reinforced.

Attride-Stirling (2001, p.386) emphasises “by recording, systematizing and disclosing our methods of analysis” meaningful and useful results can be achieved. Accordingly, Braun and Clarke’s (2006) six phase thematic analysis structured the analysis of the post Q sort semi-structured interviews. It is a method for identifying, analysing, and reporting patterns (themes) within data and can be used within different theoretical frameworks (Braun and Clarke, 2006).

3.8 Operationalising the six phases of the thematic analysis (Braun and Clarke 2006)

The six phases of the thematic analysis are identified below:

Phase 1 – Familiarisation with the data – the audio-recorded data from the ‘live’ semi-structured interviews was transcribed verbatim. The aim was to look for patterns of meaning and issues of potential interest in the data, this involved constantly moving back and forth between the entire dataset, the coded extracts of data, and the analysis that was being produced.

Phase 2 – Coding – individual extracts of data were coded and transcribed onto post it notes, matching them with data extracts that demonstrated that code. This enabled searching for data patterns and relationships between them.

Phase 3 – Searching for themes – all relevant coded data extracts were collated within identified themes, analysing codes to consider how different codes combined to form an overarching theme.

Phase 4 – Reviewing themes – *a*ll collated extracts for each theme were re-read to consider whether they formed a coherent pattern. The validity of individual themes was considered in relation to the entire dataset.

Phase 5 – Defining and naming themes – the story from each theme was captured in relation to the research question. Sub-themes were identified within the overarching themes.

Phase 6 – Writing up – the analytic narrative and data extracts were woven together and contextualised.

To summarise, the final data collection stage of my research involved participants completing Q sorts that were then subjected to factor analysis. Feedback from the Report Sheets provided further insight into participant decision making. The semi-structured interviews provided even deeper insight into participant viewpoints, with the use of thematic analysis to analyse interview data. Consequently, detailed viewpoints, underpinned by rigorous approaches to data analysis, were gathered from participants.

3.9 Operationalising Q methodology

I will now discuss how Q methodology structured the research, what ethical considerations arose, and how rigour was achieved in the process.

3.9.1 Ethical considerations

As a researcher, I was conscious of the duty of care I had to participants recruited to this research and six ethical principles were therefore relevant: beneficence, non-maleficence, fidelity, justice, veracity and confidentiality (Parahoo, 2006). These six ethical principles can be transformed into four rights of participants, the rights not to be harmed, of full disclosure, of self-determination and of privacy (Parahoo, 2006). The rights and principles of relevant organisations and the participants have been respected and upheld through the stages outlined in the invitation process and conduct of the research.

Although the study did not directly involve patients, ethical approval was nevertheless required. Permission was sought from the University of Wolverhampton (UoW), School of Health and Wellbeing Ethics Committee, and from the Research and Development Departments of one NHS Trust via the Integrated Research Application System (IRAS – project 185012). Appendix 11 is the UoW Ethical Panel decision letter (May 2015), which had some minor recommendations that were approved by my Director of Studies. IRAS and Health Research Authority (HRA) ethics approval was not completed until October 2016 (Appendix 12) and was delayed by changes in HRA ethics processes in March 2016. This delay resulted in the need to seek an extension to access nurses within the host Trust until 31 August 2017. Appendix 13 is the Trust hospital approval letter.

Informed consent can be described as ensuring that the participants have the power of free choice to participate enabling them to participate or decline based on provision of adequate and comprehensible information about the research (Polit and Beck, 2018). Participants for each stage of the research were invited to join the study via an invitation letter and participant information sheet (Appendices 14 and 15). The participants were informed that involvement in the study was entirely voluntary and that they had the right to withdraw at any stage without having to give a reason. They were not coerced in any way. No one asked for further details or withdrew from the study once consent had been obtained.

Confidentiality was maintained throughout the study. Information was divulged only to those directly involved in the study, such as research supervisors and examiners. Research data was anonymised and pseudonyms were used when quoting from participant transcripts. In this way research supervisors and examiners have been unable to link data to individual participants. Adhering to The Code (NMC, 2018a),

participants were asked before commencement of the Q sort not to identify patients or staff by name to ensure they did not breach confidentiality.

Student nurses had a choice of completing the Q sorts and post Q sort interviews at the university or in the host Trust hospital. Qualified nurses completed them at the host Trust hospital. Therefore, student nurses and qualified nurses only needed to leave the clinical area for limited time, and they were afforded a private room in a specific location.

Student nurse participants were given the choice of completing the Q sorts and post Q-sort interviews at the university or in the host Trust hospital. This choice meant they need only leave the clinical practice area for the shortest time possible (should they be on duty), and it removed the requirement to travel to the university. Before conducting the research, I was required to meet with a representative of the Trust hospital Research Department and during this meeting, I was offered the use of a room within the Research Department for Q sorts and interviews so that qualified nurses could participate without having to leave the host hospital, again reducing the time they needed to be away from the clinical area. In fact, all these activities were conducted in private rooms to maintain confidentiality and to avoid any interruptions which could have interfered with or affected the process.

Participants were asked to sign a consent form prior to commencement of the Q sort. Each retained one copy and the researcher retained a file copy (Appendices 16 and 17). Ethical guidelines on storage and access to data, as outlined by IRAS and the Trusts' Research and Development Unit, were strictly adhered to. Data was stored on an encrypted memory stick in a locked cabinet. The research data will be destroyed once the thesis is accepted.

Whilst there was no identified risk of harm, it was possible that recounting situations could upset some participants. Sources of any necessary additional support were identified for participants – both the university and the host Trust hospital offer suitable support systems. None of the participants became visibly distressed and no issues relating to breaches of confidentiality, safeguarding or unsafe practice emerged.

As a researcher I was also required to complete an e-learning course, *Introduction to Good Clinical Practice eLearning (Secondary Care)* (Appendix 18).

3.9.2 Recruitment strategy

In Q methodology the Q set, not the participants, constitutes the study sample. The "participants are the variables" (Watts and Stenner, 2012, p.72). Consequently, it was important to select participants who had "a defined viewpoint to express and [that] their viewpoint mattered in relation to the subject topic" (Watts and Stenner, 2012, p.71). Third year student nurses studying the final year of the BNurs (Hons) Adult Nursing course and qualified nurses registered in the adult field of nursing (RN, Adult Nursing) were purposely selected for this research. The rationale for this was:

- Third year student nurses have recent and ongoing exposure to educational curricula and practice experience.
- Qualified nurses represent an experienced group that is potentially more likely to have a narrower range of viewpoints influenced by the existing culture within nursing. They are no longer attending, or influenced by, full time pre-registration curriculum study.
- The adult field of nursing is the largest field in nursing and therefore strongly represented across diverse clinical areas. Also, participants are working towards, or have achieved, the same NMC requirements for successful registration.

- All participants have experienced practice within the same large inner-city Trust hospital environment and community practice settings. Therefore, both students and qualified staff have experienced both acute and community experiences.

Student nurse recruitment

Each calendar year there were two points of entry to the BNurs (Hons) Adult Nursing course, September and January. Student nurses in their third year of the September cohort were approached to engage in either a focus group or the pilot stage of the research. The January cohort was approached for the final research process. Each cohort experienced taught sessions separately and had clinical placements at differing times. This lessened the potential for participants to be influenced by the experiences and viewpoints of others involved in different stages of the research.

I was granted permission by nurse academics to present the aims of my research to student nurses. During this presentation I asked for volunteers to participate. Interested volunteers were given, or emailed, further information in an invitation letter accompanied by a participant information sheet (Appendices 14 and 15).

Qualified nurse recruitment

Nurse academics working in the university were invited to participate in the focus group or pilot stage of the research. The decision to limit recruitment in this way reflected the limited time availability of qualified nurses working in clinical practice. The latter were invited to participate in the final stage only of the research study. I was granted permission to attend two team meetings involving nurse academics, at which I presented the aims of my research and called for volunteer participants.

To recruit qualified staff I obtained permission from the Practice Placement Manager (PPM) in the host Trust hospital to attend the teaching sessions provided for such staff

by the hospital. These taught sessions prepared and updated nurse mentors to support students in clinical practice. Because qualified nurses were already attending the sessions, there would be no further impact on their time away from practice. I presented the aims of my research at the beginning of the sessions and called for volunteer participants in the final stage.

Following presentations to academics and qualified nurses, attendees were asked to give me their names directly, or via email, if they were interested or wanted further information. Interested volunteers were given, or emailed, further information in an invitation letter and participant information sheet (Appendices 14 and 15).

3.9.3 Piloting the data collection methods

The stage of the research that involved refinement of the Q sample is discussed below (see Figure 3 for all stages):

- Focus group one involved three third year student nurses.
- Focus group two involved five nurse academics.

The two focus groups were presented with the 50 Q statements (November to December 2016). Stainton Rogers (1991) and Watts and Stenner (2005) suggest that focus groups help to ensure that Q statements reflect the broad range of ideas and opinions and test the structure of the statements. Following participant feedback, the phraseology of eight statements was revisited and four additional statement were added. This resulted in a final total of 54 statements in the Q set (Appendix 19).

The next stage, conducted in January 2017, involved piloting the Q sort, Report Sheet and post Q sort interview to provide insight into timing, effectiveness and appropriateness of the process. This involved:

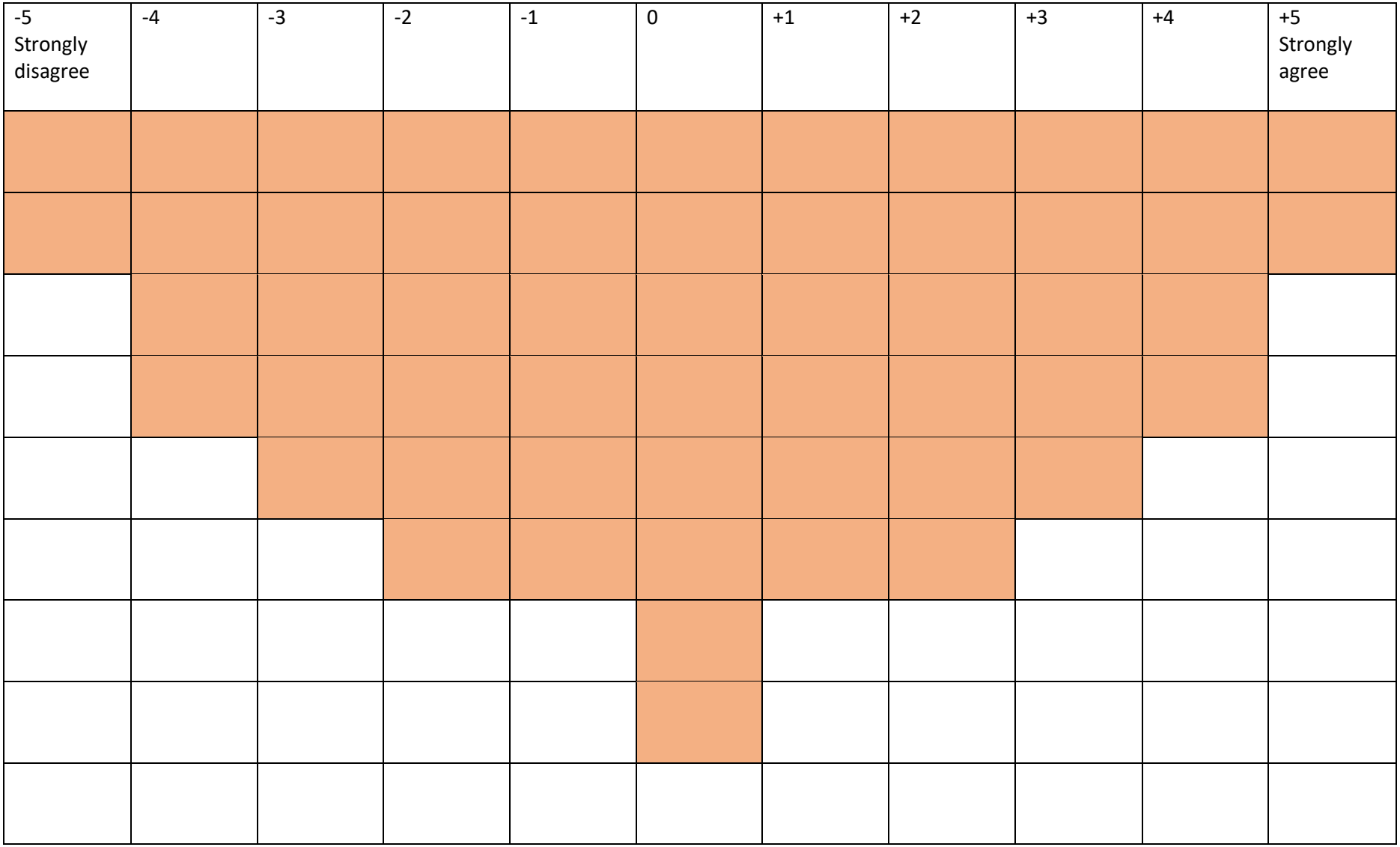
- Three third year nurse students

- Three nurse academics.

Participants were asked to use their own viewpoints in arranging the 54 statements in the Q sort onto the quasi-normal distribution grid (Figure 4). When designing the distribution grid, I was influenced by Brown (1980) who advocates an 11-point (-5 to +5) distribution for Q sets numbering 40-60 statements. I anticipated that participants would be familiar with, and have established views about, the provision of compassionate care and therefore designed a distribution grid that offered "more opportunities for responses at the extremes of distribution" (Brown, 1980, p.200). Although the range and number of statements were predetermined, the participants decided individually where each statement should be placed. Prasad (2001) believed using the forced choice method meant that respondents consider their attitudes more carefully, subsequently revealing the understanding and significance (positive and negative) that they attach to specific statements. They are not passive subjects but genuinely active participants who operate on a set of statements from an explicitly self-referential point of view.

Participants were asked to place the 54 statements along a single, face-valid dimension, from strongly agree to strongly disagree. Examples of completed Q sorts are shown in Appendix 20. Participants were given a set of sorting instructions, a *Condition of Instruction* (Stephenson, 1953; Brown, 1980; McKeown and Thomas, 2013) to ensure that they all understood the process and were answering the same

Figure 4 – Distribution grid



question (Appendix 21). The Q statements were printed onto cards of the same size and colour and were laminated to ensure ease of handling and manipulation. The statement was printed on the front of the card and the statement number on the back. The completed Q sorts were then photographed by the researcher.

Following completion of the Q sort participants were asked to complete a Report Sheet. This provided the opportunity to share their rationale for placing statements in the extreme distribution columns (-5, -4 strongly disagree to +5, +4 strongly agree). They were also asked to respond to the statement "*As you reflect on your responses to the 'card sort' it would be really helpful if you could identify how you believe nurses maintain compassionate care….*" (Appendix 10).

The post Q sort semi-structured interview was then conducted. Participants were asked *'How did you find the process of sorting the cards…?'* and *'Is there any further information you wish to add with regards to your decisions about where you placed the cards across the columns...?'* The structure of these two questions and the freedom, when appropriate, to digress from the schedule, meant I was able to gain more detailed data. Participants were forthcoming with their feedback to these questions, with the majority commenting that this was a new and interesting approach to exploring their views about compassionate care.

The pilot stages confirmed that the Q sort, completion of the Report Sheet, and the interview were understood and met the requirements of the research process. The final stage of the research process could therefore commence.

3.9.4 Data collection

For the final stage of my research, 30 participants were purposefully selected, 15 third year student nurses and 15 qualified nurses from differing clinical areas. The

demographic information of the participants is shown in Tables 4 and 5. The student nurses had an age range from 24 to 54 years, with a mean age of 34 years (Table 4). The qualified nurses had an age range of 27 to 62 years, with a mean age of 43 years (Table 5).

Table 4 – Demographic information of student nurse participants

Participant reference	Gender	Participant age	Role	Practice Area	Length of time in practice
S1	Female	29 years	Student nurse	N/A	3rd year
S2	Female	54 years	Student nurse	N/A	3rd year
S3	Female	27 years	Student nurse	N/A	3rd year
S4	Male	25 years	Student nurse	N/A	3rd year
S5	Female	26 years	Student nurse	N/A	3rd year
S6	Female	41 years	Student nurse	N/A	3rd year
S7	Female	36 years	Student nurse	N/A	3rd year
S8	Female	26 years	Student nurse	N/A	3rd year
S9	Female	44 years	Student nurse	N/A	3rd year
S10	Female	38 years	Student nurse	N/A	3rd year
S11	Female	36 years	Student nurse	N/A	3rd year
S12	Female	37 years	Student nurse	N/A	3rd year
S13	Female	24 years	Student nurse	N/A	3rd year
S14	Female	35 years	Student nurse	N/A	3rd year
S15	Female	38 years	Student nurse	N/A	3rd year
Age range	24 to 54 years				
Mean	34.4 years				

Table 5 – Demographic information of qualified nurse participants

Participant reference	Gender	Participant age	Role	Practice Area	Length of time in practice
Q1	Female	40 years	Sister	Medical Unit	20 years
Q2	Female	45 years	Practice Support Facilitator	Not ward based	16 years
Q3	Female	43 years	Practice Support Facilitator	Not ward based	18 years
Q4	Female	62 years	Renal Practice Development Nurse	Renal Unit	32 years
Q5	Female	49 years	Research Nurse	Not ward based	17 years

Q6	Female	50 years	Research Nurse	Not ward based	20 years
Q7	Female	40 years	Staff Nurse	Renal medicine	15 years
Q8	Female	50 years	Senior Sister	Haemodialysis Unit	30 years
Q9	Female	43 years	Sister	Medical ward	15 years
Q10	Female	41 years	Senior Sister	Medical ward	9 years
Q11	Female	43 years	District Nurse	Community	22 years
Q12	Female	27 years	Staff Nurse	Renal ward	5 years
Q13	Female	36 years	Staff Nurse	Medical ward	3 years
Q14	Female	30 years	Staff Nurse	Renal Unit	3 years
Q15	Female	44 years	Sister	Intensive Care Unit	17 years
Age range	27 to 62 years				
Mean	42.86 years				

Brown (1980) suggests that the aim of Q methodology is to establish the existence of viewpoints and to understand, explicate and compare these. This can be achieved through the engagement of very few participants, even down to a single individual. My aim was not to seek generalisation to a population but to learn more from the factor analysis and additional qualitative methods about the collective and individual viewpoints of participants. Also, the challenge of recruiting qualified nurses to the study cannot be overestimated, given the competing demands on them. Nevertheless, within my study, a range of roles and clinical practice areas was represented, providing a breadth of insight to the subject topic.

The final data collection process was conducted from April to August 2017. Data were gathered before the Q sorting process that included students' gender, and qualified nurses' gender, practice areas, and clinical roles. This data could indicate a pattern, or highlight individual results associated with specific background information.

Student nurses were individually invited to complete the research process at the university site, or the Research Department of the Trust hospital. In both situations a

private room was booked in advance and the location communicated to the student nurse by email. The decision to conduct the interview directly following the Q sort was influenced by time availability, as it meant participants did not have to return for a later interview. Following completion of the Q sort and the Report Sheets, audio recording equipment was switched on and the interview commenced using the two questions "*How did you find the process of sorting the cards…?*" and "*Is there any further information you wish to add with regards to your decisions about where you placed the cards across the columns....?*"

Three participants identified that they would have liked the opportunity to place more cards in the higher ranked distribution columns. When sorting the statements it is possible to use a free distribution approach rather than a forced distribution. For example, placing more or fewer statements across the range of spaces in the distribution grid (Figure 4). However, I wanted to be able to compare extreme statement results across all participants, and completion of the Report Sheet and the interview offered the opportunity to discuss any challenges in sorting decisions. Also, Brown (1980, pp.288-9) suggests that "distribution effects are virtually nil", the existence of factors being affected almost entirely by the patterns of statement placement. This information was discussed with the three participants and all were happy to continue to use a forced distribution approach.

3.9.5 Intercorrelation and factor analysis of the Q sorts

The PQ Method 2.35 program was used to analyse the Q sorts (Schmolck, 2014). PQ Method 2.35 offers a choice of factor extraction and rotation methods and the extensive output files contain useful statistical information. Data are analysed using correlation and by-person factor analysis; statistical analysis is not performed by variable, trait, or statement, but rather by person. Factorisation reveals patterns of

viewpoints while allowing the researcher to compare emerging themes. The initial correlation matrix reflects the relationship of each Q sort configuration with every other Q sort configuration. The factor analysis produces a set of factors derived from shared viewpoints of participants that load on to each factor, the "normalised weighted average statement scores of respondents that define the factor" (van Exel and de Graf, 2005, p.9). These scores are then merged to create factor arrays which are reverted into the original values used in the sorting process for ease of interpretation (+5, to -5), creating a model sort. The factor array "represents how a hypothetical respondent with 100% loading on that factor would have ordered all the statements of the Q set" (van Exel and de Graf, 2005, p.9).

The factors were extracted using centroid factor analysis and varimax rotation. Centroid analysis extracts factors for rotation from the initial set of factor loadings and the researcher decides on the number of factors extracted (Watts and Stenner, 2012). At times, individual Q-sets may not correlate with any factor; by rotating the factors their relationships with other positions can be brought to the fore (Brown, 1993). Factor rotation enables the researcher to view every possible commonality amongst participants' positions, both across and within factor clusters (Brown, 1993). Accordingly, the most appropriate and theoretically informative rotated solution can be selected (Watts and Stenner, 2012).

Watts and Stenner (2005) suggest that some Q methodologists may be critical of varimax rotation which is perceived to reveal only the most mathematically informative solution, rather than theoretical ones. Nonetheless, varimax rotation is consonant with the aims of Q methodology, which are to reveal the range of participant preferred viewpoints maximising the amount of variance by seeking a mathematically superior solution (Watts and Stenner, 2005).

Following centroid factor analysis, participants with a loading of .35 and above were flagged for varimax rotation to maximise the loading in each factor. Using the equation below (2.58 = standard deviation from the mean) (Brown 1980 pp.222-3), I calculated that a significant factor loading at the 0.01 level would be 0.35 and above:

$$2.58 \div \sqrt{No.of\ items\ in\ the\ Q\ set})$$
$$2.58 \times (1 \div \sqrt{54}\,);\ 2.58 \times (1 \div 7.348);\ 2.58 \times 0.136 = \pm 0.35$$

Any Q sort with a single rotated factor loading above that level would define the viewpoint of that factor. Q sorts can be 'flagged' automatically or manually to be included in subsequent calculations with the purpose of maximising differences between factors (McKeown and Thomas, 2013).

I conducted the factor analysis several times, rotating between two and six factors. Each time I checked for explained variance and eigenvalue, the number of significant participants loading and not loading on any factor, the number of participants confounded across more than one factor, and the correlation between factors. Eigenvalues are indicative of a factor's statistical strength and explanatory power, only eigenvalues greater than 1.0 were extracted to satisfy the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960). Also, factors were only included that had two or more significant factor loadings following extraction (Watts and Stenner, 2005). A two-factor solution was selected, as the two highest loadings on Factor One (F1) were 0.75 and 0.74 (eigenvalue 10.31), and for Factor Two (F2) 0.49 and 0.44 (eigenvalue 1.97). Several Q sorts possessed a significant factor loading across the two study factors and were therefore *confounded.* Manual flagging did not include the confounded Q sorts, resulting in more clearly distinctive factors (highlighted in). The remainder comprised a total of 18 participants, F1 (n=13), and F2 (n = 5).

Table 6 – Factor Matrix with an X indicating a defining sort		
Sorts	Factor 1	Factor 2
S = Student nurses		
S1	0.0594	0.4920 X
S2	0.6394 X	0.3143
S3	0.4333	0.5762
S4	0.0145	0.5360 X
S5	0.4822 X	0.0901
S6	0.6826 X	0.3367
S7	0.4484	0.4072
S8	0.5847	0.3784
S9	0.5779	0.4694
S10	0.6092 X	0.3008
S11	-0.2871	0.4073 X
S12	0.0679	0.5710 X
S13	0.4997 X	0.1927
S14	0.6238 X	0.1112
S15	0.5777	0.4433
Q = Qualified nurses		
Q1	0.4402	0.4649
Q2	0.3846	0.5393
Q3	0.7117 X	0.1866
Q4	0.6929 X	0.0450
Q5	0.7416 X	-0.0028
Q6	0.4071	0.3956
Q7	0.6046	0.4246
Q8	0.6431 X	0.0872
Q9	0.3908 X	0.3301
Q10	0.5817 X	0.0131
Q11	0.3964	0.3898
Q12	0.7259 X	-0.0302
Q13	0.1606	0.4155 X
Q14	0.4197	0.4845
Q15	0.5706	0.4062
% Explained variance	27	14
In total, 18 participants contributed to factor interpretation.	Factor One: 6 student nurses 7 qualified nurses	Factor Two: 4 student nurses 1 qualified nurse

In my results 34% of the variance in Q sort F1 and 7% of the variance in Q sort F2 had been accounted for by the study factors. There was 41% common variance in how much the Q sorts hold in common with all the other Q sorts in the group (Kline, 1994, suggests anything in the region of 35-40% or above for total study variance would

ordinarily be considered a positive solution). The eigenvalues and variance estimates provide similar information to the communality. However, eigenvalues relate to each factor rather than each Q sort. Collectively they offer a clear and potential explanatory power of an extracted factor. indication of the strength The two factors included in my research accounted for 41% of the total study variance,

Once the factors were selected, each factor was analysed qualitatively, the interpretation being a gestalt process, recognising that individual statements contribute to a whole viewpoint (Watts and Stenner, 2005). This requires careful reading of which statements are found in strongly positive and negative positions, as

Table 7 – Factor Q-sort values for each statement

		Factor Arrays	
No.	Statement	1	2
1	More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say.	+2	+1
2	Professional development is important in improving standards of practice.	+4	+3
3	It is harder to provide compassionate care when my values conflict with the organisational values.	0	+2
4	It is unprofessional to show my personal emotions about a patient.	0	-4
5	It is OK for things affecting my personal life to influence the care I provide.	-5	-5
6	I am much more likely to be short tempered with a patient when I am being unfairly treated.	-3	-1
7	It's OK to use humour with patients.	+2	+4
8	It helps me to give good care when I say what I am feeling to the patients.	-1	+3
9	Colleagues don't like it when I express my feelings at work.	0	-3
10	It's easier to provide compassionate care when I like the patient.	-4	+2
11	Teaching in the university creates unrealistic expectations of compassion that I cannot achieve.	-1	-1
12	The more time I spend with one patient, the poorer the care another receives.	-4	+1
13	Managers must be visible role models showing compassion.	+5	0
14	Regardless of the knowledge and skills of the mentor I can still maintain high standards of care.	+4	+1
15	Undercurrents in my workplace influence the care I provide.	-2	0
16	If we can measure compassionate care we are more likely to achieve it.	0	-2

17	I prefer to focus on physical aspects of care.	-3	-3
18	It is frustrating when my hard work is not appreciated by patients.	-2	0
19	I find it easier to provide compassionate care when I share the same background or culture with the patient.	-3	+3
20	The longer I work in practice the less able I am to provide compassionate care.	-5	-1
21	When work is busy standards of care are inevitably lower.	-2	+5
22	Good physical care is more important than compassion.	-3	-2
23	To protect myself from undue stress it is important I distance myself from the patient.	-4	-5
24	When a patient's lifestyle has resulted in their condition it is difficult to be as caring.	-4	-3
25	My own life experiences of distress mean I care more effectively for the patient.	0	+4
26	Compassionate care is not critical to safe care.	-2	+1
27	Organisational targets get in the way of compassionate care.	0	+4
28	If staff are kind to each other then compassionate patient care is more likely.	+3	+2
29	I am influenced by the values and behaviours of the team I work with.	0	0
30	My manager/mentor supports me to learn from examples of excellent care.	+4	+2
31	When I feel taken for granted by my manager its harder for me to give compassionate care.	-3	+1
32	Self-disclosure helps me build rapport with the patient.	-1	0
33	The more knowledgeable I am the more compassionate I become.	+3	-2
34	Compassion cannot be taught it is something that you have.	+3	+5
35	Managerial values focusing on safety and targets are incompatible to achieving compassionate care.	-1	+2
36	Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.	-2	-1
37	Feedback from colleagues helps me to overcome any negative attitudes I may have.	+2	-4
38	If I am told a relative is likely to complain I can make more effort to prevent this.	0	-1
39	My own personal safety is my main priority.	-2	-3
40	Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives.	+1	-4
41	Relatives are reluctant to complain as they believe this will impact on the care the patient receives.	+2	-2
42	Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance.	+1	-1
43	The organisational culture which I work within builds trust and honesty.	+3	0
44	Demonstrating compassionate behaviours influences patient outcomes positively.	+5	+2
45	Ward leadership has enormous impact on the quality of compassionate care provided by team members.	+4	-2
46	Teams within wards that feel less supported by their manager provide poorer compassionate care.	+2	0
47	Opportunities to discuss issues in practice are regularly available.	+1	-4

48	Recruitment of already compassionate individuals to nursing ensures compassionate care.	+3	-2
49	In the practice area team members have clear roles and responsibilities.	+2	-3
50	The nursing course does not prepare you to face the long term emotional demands of practice.	+1	+3
51	Compassion isn't limitless and sometimes I have given all I can.	-1	+4
52	The way relatives treat me has influenced my understanding of compassionate care.	-1	0
53	I feel equipped to deal with patients' suffering.	+1	+1
54	Education has equipped me to challenge uncompassionate practice.	+1	+3
	Variance = 7.000 Standard deviation = 2.646		

well as of those in a neutral position. Table 7 displays the Q sort values for each statement. Furthermore, each factor may have distinguishing statements, whereby participants have placed statements in a significantly different position to the other factor. Similarly, consensus statements may be present – those statements agreed upon in both factors. The overall interpretation is constructed by careful reference to the positioning and configuration of the items in the factor array.

To contribute to a holistic analysis, I produced "crib sheets", as suggested by Watts and Stenner (2012, p.150), to support a systematic, methodical and holistic approach to the factor interpretations (Appendix 22). The crib sheet identified those important issues about which the F1 viewpoint was polarised and also how that viewpoint was polarised relative to F2. Also, it identified statements that were ranked towards the middle point of the distribution. This process generated "a sense of the overall story being told" by the various statement rankings (Watts and Stenner, 2012, p.156).

3.10 Validity, reliability, and trustworthiness

Because of its qualitative aspects, questions of research validity in Q methodology are assessed differently than in quantitative research. Brown (1980, pp.174-5) argues that "the concept of validity has very little status (relative to Q methodology), since

there is no outside criterion for a person's own point of view." Valenta and Wigger (1997) suggest that the validity of a Q study can be evaluated by content, face, and Q sorting validity. Each participant's rank ordered set of statements is considered a valid expression of their opinion. Content validity is addressed by a thorough literature review. Item validity does not apply in the study of subjectivity. In Q methodology individual interpretation is apparent from the rank ordering of statements and post Q sort interview. In my research, validity was exercised with the use of focus groups, a pilot study, reflexivity, peer debriefing, respondent validation and triangulation.

Within the pilot stages completion of the Q sort, Report Sheets and the semi-structured interviews tested the format and structure to be used in my approach to data collection. Kezar (2000, p.385) identified that pilot studies can obtain first-hand, "real world" experience of the issue studied; they can enhance the research design, conceptualization, interpretation of findings, and ultimately the results.

Creswell (2009) believes that researchers seek external interpretations to improve the validity of their own research, and Long and Johnson (2000) highlight that conferences and workshops are an essential part of peer debriefing within doctoral studies. Supervisory meetings, Annual Performance Reviews, and the opportunity to present my research and evolving findings at five research conferences provided feedback and critique. Appendix 23 provides an example of the research poster, and power point presentation presented at a conference.

Creswell (2009) suggests that using different data sources can improve the validity of the research. Triangulation of data was achieved by using Q-sorts, Report Sheets and semi-structured interviews. The interview process allowed individual expression of viewpoints and, to maximise reliability and trustworthiness, all interviews were recorded and transcribed verbatim. Extracts of raw data were embedded in the

analytic narrative to illustrate the complex story of the data, supporting the validity of the analysis.

The reliability of Q-sorting has been verified through test-retest studies and assessment of reliable schematics (Valenta and Wigger, 1997). Brown (1980) maintains that a Q sort can be replicated with 85% consistency up to a year later. Brown (1980) adds that an important notion behind Q methodology is that only a limited number of distinct viewpoints exist on any topic and a well-structured Q sample, containing the wide range of existing opinions on the topic, will reveal these perspectives. Van Exel and de Graaf (2005, p.3) suggest that "the most important type of reliability for Q methodology is replicability: will the same condition of instruction lead to factors that are schematically reliable", representing similar viewpoints, "using similarly structured yet different Q samples when administered to different sets of participants?"

When considering generalisability, Q methodology does not claim to have identified viewpoints that are "consistent within individuals across time" (Watts and Stenner 2005 p.85). Nevertheless, currently expressed viewpoints are captured in, "the emergent manifold of shared viewpoints" (Watts and Stenner, 2005, p.86).

Lincoln and Guba (1985) refined the concept of trustworthiness to parallel the conventional quantitative assessment criteria of validity and reliability, introducing the criteria of credibility, transferability, dependability and confirmability. To meet this criterion information already provided can be incorporated with that given below:

- *Credibility* – to support findings, the viewpoints of participants were represented using direct quotations from the Report Sheets and post Q sort interviews. Data

triangulation and peer debriefing with the supervisory team provided an external check on the research process.

- *Transferability* – those seeking to transfer the findings to their own site can judge transferability from detailed descriptions in my research (Lincoln and Guba, 1985).
- *Dependability* – the research process was logical, traceable, and documented. Discussion of the design and operationalisation of my research is supported by examples from my decision-making process. Examples are the development of Q statements, coding, and stages of theme and sub-theme development.
- *Confirmability* – the research interpretations and findings were clearly derived from the data and linked to evidence. Confirmability is established when credibility, transferability and dependability are achieved.

3.11 Reflexivity

Reflexivity is a key feature of qualitative research and "facilitates a critical attitude towards locating the impact of research(er) context and subjectivity on project design, data collection, data analysis, and presentation of findings" (Finlay and Gough, 2003, p.22).

Throughout the analysis of data, I acknowledged that my own actions and decisions would inevitably impact upon the meaning and context of the experience under investigation (Horsburgh, 2003). Several processes were incorporated to reduce personal influences on the interpretation and analysis of the research. Personal reflection and reflexivity, challenging my own assumptions, presenting progress to others formally and informally, and completing the Q sort myself (Appendix 24) increased my own awareness of positionality. I recognised that participants may have been aware of my role within the university, as a senior academic, and I wanted to

reduce any unnecessary influence arising from that during data collection. When engaging with participants I presented my role as a researcher, my aim for impartiality, and my focus on gathering *their* viewpoints on compassionate care. I believe my reflexive stance helped me to strengthen my trustworthiness and their understanding of me as a researcher, and as Alvesson and Skoldberg (2017) suggest, allowed influential aspects to be realised without letting one aspect dominate.

Cordingley, Webb and Hillier (1997) suggest that Q methodology incorporates less chance for researcher bias than other interpretive approaches as the factors are derived statistically from the results of the Q sort rather than the researcher's process of analysis. The feedback from the Report Sheets also offered additional qualitative data and an opportunity for cross reference to the results of the factor analysis.

When commencing the thematic analysis, I was aware that I was the instrument of analysis, making judgements about coding and theme development, as well as contextualising the data. Braun and Clarke's (2006) six phase thematic analysis provided a well-structured approach, and participants' viewpoints were represented using direct quotes, contributing to authenticity and accuracy.

Engaging with differing approaches to data analysis was challenging and time-consuming. Nevertheless, completion revealed a richness of data analysis I had not anticipated.

3.12 Summary

This chapter has detailed my ontological and epistemological orientations. The selection of Q methodology aligned with my stance as an interpretivist and supported the aims of my study. Additional data collection methods enriched my research

findings. I am confident that my research design is consistent with my beliefs and values as a researcher and resulted in a process that is clearly robust.

Chapter four will now discuss the findings from my research.

Chapter Four – Findings

This chapter presents the results and analysis of the Q sorts, report sheets, and the post Q sort semi-structured interviews.

4.1 Results from the factor analysis and thematic analysis.

Following intercorrelation and factor analysis of the completed Q sorts, two factors were extracted and varimax rotation was performed. The resulting values were analysed both statistically and qualitatively. Statistical information was presented in Chapter Three (Table 6 **–** Factor Matrix with an X Indicating a Defining sort and Table 7 **–** Factor Q sort Values for each statement). Further statistical information is presented in:

Appendix 25 **–** Correlation Matrix Between Sorts: this represents the extent of the relationships between all Q sorts in the study.

Appendix 26 **–** Unrotated Factor Matrix: the factor loadings show the extent to which each individual Q sort is associated with each of the study factors following extraction, but before rotation has taken place.

The factor analysis resulted in two factors (Factor 1 (F1) and Factor 2(F2)) that were statistically significant. F1 had an eigenvalue of 10.31 and F2 an eigenvalue of 1.97. These values offer a safeguard of factor reliability (factors with an eigenvalue below 1.0 serve no data reductive purposes as they explain less of the overall study variance than would any single Q sort, Watts and Stenner, 2012). Participants that had a significant loading in relation to both study factors (confounded Q sorts) did not contribute to the factor estimates. This resulted in 13 participants contributing to F1 and 5 participants to F2. Demographic information of the participants in F1 and F2 is presented in Table 8.

Table 8 – Demographic information of participants in Factor 1 and Factor 2					
Participant reference	Gender	Participant age	Role	Practice Area	Length of time in practice
Factor 1 – student nurse participants					
S2	Female	54 years	3rd year student nurse	N/A	N/A
S5	Female	26 years	3rd year student nurse	N/A	N/A
S6	Female	41 years	3rd year student nurse	N/A	N/A
S10	Female	38 years	3rd year student nurse	N/A	N/A
S13	Female	24 years	3rd year student nurse	N/A	N/A
S14	Female	35 years	3rd year student nurse	N/A	N/A
Age range Mean	24 to 54 years 36.33 years				
Factor 1 – qualified nurse participants					
Q3	Female	43 years	Practice Support Facilitator	Not ward based	18 years
`Q4	Female	62 years	Renal Practice Development Nurse	Renal Unit	32 years
Q5	Female	49 years	Research Nurse	Not ward based	17 years
Q8	Female	50 years	Senior Sister	Haemodialysis Unit	30 years
Q9	Female	43 years	Sister	Medical ward	15 years
Q10	Female	41 years	Senior Sister	Medical ward	9 years
Q12	Female	27 years	Staff Nurse	Renal ward	5 years
Age range Mean	27 to 62 years 45 years				
Factor 2 – student nurse participants					
S1	Female	29 years	3rd year student nurse	N/A	N/A
S4	Male	25 years	3rd year student nurse	N/A	N/A
S11	Female	36 years	3rd year student nurse	N/A	N/A
S12	Female	37 years	3rd year student nurse	N/A	N/A

Age range Mean	25 to 37 years 31.75 years				
Factor 2 – qualified nurse participant					
Q13	Female	36 years	Staff Nurse	Medical ward	3 years

There was a low correlation between the two factor scores of 0.17, indicating differences. Participants in F1 viewed the organisation as working with them to overcome barriers to compassionate care, whereas participants in F2 viewed the organisation as a barrier to achieving compassionate care. Accordingly, the factor titles are:

F1 – ***There are challenges, but we are working to achieve compassionate care together.***

F2 – ***Organisational targets and workload pressures result in lower standards, limiting the provision of compassionate care.***

The thematic analysis of the interview data involved coding, collation, and theme development (Braun and Clarke 2006) within the overarching themes of *Organisational Issues, Personal/relational Issues,* and *Educational Issues*. An example of this process is provided in Table 9.

Table 9 – Thematic Analysis - Examples of participant statements, subsequent coding and sub-theme development within overarching themes.

Overarching category	Sub theme	Coding	Participant statements
Personal/ relational Issues Demonstrating consensus across F1 and F2.	Commitment, passion, and motivation to nurse	I wanted to care for others	"I am proud of what I do, recognise that we care, I love what I do. I believe in compassionate care" (S1) "I came into nursing because I wanted to care" (S4) "I wanted to care for patients, to make them feel valued" (S10) "caring for someone and seeing them smile, that's worth loads" (Q4)

		Committed to care	"wanting to do the best you can, to care for others" (Q9) "the people you are looking after are your priority" (S4) "I had compassion for people, and really wanted to share this, to care" (S12) "providing compassionate care is what our main aim is" (S13) "it's important to deliver compassionate care and to show the patient that they are unique" (S14) "as long as (the patients) are happy and their care needs are being met, that's all that matters to me at the end of the day" (Q10) "your main priority is to meet the needs of patients [then] you know you have done a good job" (Q13)
		Wanted to be as nurse	"that kind of caring (is) in you… I believe those *are* the people that come into nursing as I don't believe you come into it for anything else" (S2). "I think if you want to be a nurse you have a passion to nurse then I think that comes from you being that innate person you having that compassion wanting to care for a patient" (S11) "I mean for me nursing as a career is something I've always wanted to do and naively I perceive that the majority of people working within this environment also want to be here, caring for people, doing the best they can basically" (Q5). "they want to be nurses because they are compassionate and caring" (Q8) "Nursing was something I always wanted to do" (Q13)
	Maturity	The value of experience	"my own experiences made me caring" (S1) "If compassion is in… that will still come through to your patients, perhaps that's because I am a mature student" (S2).

		Maturity contributed to skills and knowledge	"With experience able to deal with suffering" (S6). "I came into nursing having experienced, built up on life skills, built up communication" (Q3) "the older the student, the more life experience, shows a lot more compassion" (Q10) "I worked in care, volunteering, so I had experience so was prepared" (Q13)

The structure and abbreviations used to present the findings from the factor analysis and thematic analysis are presented in Table 10.

Table 10 – The conventions used when presenting the factor analysis and thematic analysis results

	Abbreviation used and presentation format
Factor analysis	FA
Thematic analysis	TA
S1, S2, etc	Student nurses
Q3, Q4, etc	Qualified nurses
Factor One	F1 - Represents the 13 participants that contributed to this factor = S2, S5, S6, S10, S13, S14, Q3, Q4, Q5, Q8, Q9, Q10, Q12
Factor Two	F2 - Includes the 5 participants that contributed to this factor = S1, S4, S11, S12, Q13
Results from the factor analysis	Statement number is presented first, then factor, then ranking of statement. Example when presenting one factor result: (1: F1 +3) or (5: F2 -5) Example when presenting factor results for comparison: (1: F1 +3, F2 +4) or (5: F1 -5, F2 -5).
Participant feedback from the Report Sheets	RS will be used to indicate feedback from Report Sheet.
Participant feedback from the post Q sort interviews (thematic analysis)	TA will be used to indicate feedback from post Q sort interview. Participant feedback is presented as quotations, and reference made to the participant number and whether it comes from a student nurse or qualified nurse e.g.,

	S1, S2 (indicates student nurse)… Q3, Q4 (indicates qualified nurse).
Identifying number of student nurses and qualified nurses within the RS and TA feedback	When presenting the results from several participants, first the total number of participants are presented then the numbers of student nurses (S) and qualified nurses (Q): Example for single factor result: (F1 = 4 (2S; 2Q)) Example for both factor results: (F1 = 10 (4S; 6Q), F2 = 4 (3S; 1Q)).

Although there were clear differences across factors there was also consensus, as Jeffares and Skelcher (2011) identified some Q statements (known as consensus statements) may be ranked consensually across factors. For clarity, firstly consensus in the factor analysis results will be presented, followed by the differences between F1 and F2. Feedback from the RSs provides individual participant perspectives on the placing of the Q statements in the extreme columns of the distribution grid (-5, -4, +4, +5). It is acknowledged that individual perspectives from RS feedback may not reflect the shared viewpoints of the entire group. The results from the TA of interview data extend insights into participant placing of the statements across the distribution grid (from extreme to neutral). Finally, a summary of the results is presented.

4.2 Consensus across Factor 1 and Factor 2

4.2.1 Factor analysis results

When considering the impact of communication on relationship building, both factors exhibited low regard for the idea that non-verbal messages from patients should receive more attention than what patients say (1: F1 +2, F2 +1). Further explanation was provided by individual participants in the RS feedback, “compassion involves recognising <u>all</u> signals by showing interest in the person and watching as well as listening” (Q4), it “requires the nurse to be more intuitive to the patient’s needs expressed verbally and non-verbally” (Q13). Integral to their comments in the RS

feedback, was the view that communication was a two-way process between nurse and patient, requiring investment from the nurse. Participant S13 said “it is essential that the patient is approached, involved in their care, and so patient collaboration is essential, and may relieve stress rather than add to it”.

Allied to collaboration and relationship building, participants shared a view of the importance of not being judgemental towards the patient (24: F1 -4, F2 -3). Participant Q12 captured this in their RS feedback as, “you aren’t there to judge, you are there to care.” Participants also shared the view that to protect themselves from undue stress they should distance themselves from the patient (23: F1 -4, F2 -5). Participants attached importance to holistic care, with shared disagreement that it was preferable and more important to focus on physical care (17: F1 -3, F2 -3; 22: F1 -3, F2 -2). This view was evidenced in the RS feedback of participants (F1=10 (4 S; 6 Q), F2=4 (4 S; 1 Q). An example is, “to care holistically for my patient, their mental wellbeing is important just [as much] as physical and emotional alongside cultural and religious” (S1). Within this collaborative relationship, participants strongly disagreed that it was acceptable for personal issues to influence the provision of compassionate care (5: F1 – 5, F2 -5). This view was supported by RS feedback: “Patients have enough problems; they do not need to hear mine” (Q8), “Nursing and my personal life are two separate entities” (S11). The shared view from the FA results and the individual feedback from the RSs were that communication and collaboration with the patient were integral to compassionate relationship building.

There was recognition that when staff are kind to each other this impacts positively on the provision of compassionate care (28: F1 +3; F2 +2). They were, however, indifferent to the view that they were influenced by the values and behaviours of the

team (29: F1 0; F2 0). They recognised the benefits of team collaboration but were also guided by their own beliefs and values.

When considering the development of compassion participants across both factors shared the view that compassion cannot be taught (34: F1 +3, F2 +5). To offer explanation, in the RS feedback participants commented that compassion is something that "you have" (F1=4 (2S; 2Q)), it is "innate" (F2=2 (1S; 1Q)), it "comes from within" (F1=7 (2S; 5Q), F2=4 (3S;1Q)), "from my upbringing" (F1=3 (1S;2Q), F2=3 (2S;1Q)), or "compassion comes from experience and understanding it doesn't come in a textbook" (S1). Participants viewed the origins of compassion as embedded in early life, cultivated and influenced by life experiences.

There was agreement across both factors that professional development is important in improving standards of care (2: F1 +4, F2 +3), typified by the response from participant Q5, "we learn new ways to improve and enhance current practice". Feedback from the RSs related professional development to ensuring safe, effective, and up to date practice (F1=7 (3S;4Q), F2=3 (2S;1Q)), and meeting the required standards of care.

4.2.2 Thematic Analysis Results

Organisational issues

Importance of team collaboration and compassionate team working - From the TA results, 12 participants across both factors emphasised the positive impact of showing kindness and compassion to colleagues. This is captured in feedback from participant S12, "when you have compassion for other people that you are working with then you've got more compassion for your patients" (S12). Participant Q8 identified that this was enabled through "reflection, discussion, supporting each other."

Participants linked the achievement of team collaboration and cohesiveness to supportive structures that enabled relationship building within the team.

Personal/relational issues

Compassionate relationship building - The TA results reinforced the importance of good communication between nurse and patient. This was articulated by participants as "getting down to the patient's level… build a rapport with patients, be compassionate too" (S4), "let the patient know what is going on with their treatment or their condition; that way I feel like they'll understand and they'll feel valued in the process of whatever they are going through" (S10). This feeling of being valued was viewed as preventing feelings of isolation and encouraging relationship building. Participants recognised that this could be actioned by the nurse connecting and collaborating with the patient, demonstrating genuineness and congruence. As participant Q4 stated, "if it doesn't come natural… it's going to be a false thing, a play act" and participant Q13 added "the patient will sense insincerity." In the TA results, both factors identified the need to collaborate with relatives/carers and colleagues to ensure effective communication. Participants referred to the associated attributes required in compassionate relationship building as communication, kindness, caring, empathy, dignity, respect, being non-judgemental, courage, commitment, and competence.

There was strong consensus across both factors about the importance of not being judgemental (F1=11 (6S; 5Q), F2=4 (S3; Q1)). Participant Q9 stated "as long as we know we are doing the best we can… not judging the patient's lifestyle…". Participant S4 added, "if that person has lung cancer because they are a smoker, or something like that, some people might say 'so it is their fault', but can you be 100% sure that it was because of the lifestyle choice that they make, and you need to consider the

reasons that they did this". Participant S13 summed this up, "by avoiding judgements, with [the patient's] needs being the centre of care, then the nurse provides compassionate care".

Participants said they separate personal and work life issues (F1=11 (6S; 5Q), F2=4 (S3; Q1)), thereby mirroring the FA results. This is reflected in their feedback, "you do leave your issues at home… you cannot let that affect the care that you are giving" (S4); "I don't think what I feel is important to the patient, they're not there to take on board my opinions, my stress, and my worries" (Q12). Participants viewed this separation as necessary, in order to focus on care giving and protect the patient from additional stress.

Commitment, passion and motivation to nurse - In the TA results participants made explicit their commitment and motivation to nursing and the provision of compassionate care (F1=10 (4S; 6Q), F2=4 (3S; 1Q)). This was evident in statements such as: "that kind of caring [is] in you… I believe those *are* the people that come into nursing" (S2); "they want to be nurses because they are compassionate and caring" (Q8); "I think if you want to be a nurse you have a passion to nurse… wanting to care for a patient" (S11).

Participants also related their maturity to their ability to provide care with compassion (F1=10 (4S; 6Q), F2=5 (4S; 1Q)). Participants stated, "I came into nursing having experienced, built up on life skills, built up communication" (Q3); "the older the student, the more life experience, [they] show a lot more compassion" (Q10). Participants also suggested that their maturity, and associated life experiences, helped them to overcome adversity (F1=7 (4S; 6Q), F2=3 (2S; 1Q)).

Educational issues

The origins of compassion - In TA results participants recognised compassion as "innate" (F1=8 (6S; 2Q), "embedded at an early age" (F1=9 (6S; 3Q), F2=5 (4S; 1Q)), it is "within you" (F1=3 (1S; 2Q), F2=3 (2S; 1Q)). Although they stated that compassion cannot be taught, 15 participants said clinical experiences involving compassionate care-giving had enhanced their understanding (F1=13 (7S; 6Q), F2=5 (4S; 1Q)). These participants believed you need to engage in "real life situations that really affect people, it's not just a classroom, it's not theoretical" (Q4), the situation has to be "real" (F1=8 (5S; 3Q), F2=3 (2S; 1Q)). Further insight was provided in their comments, "you could not take Jo Bloggs off the street and say… show compassion toward this person… if they aren't the kind of person" (S4); "it's not something you can go and sit in a classroom and learn" (S12). Participants associated the development of compassion with their upbringing and life experiences. They recognised that attempting to teach compassion without relating it to, and applying it through, clinical experience would be difficult.

Importance of professional development - The TA results linked the importance of professional development to "improving standards of practice" ((F1=1 (1S), F2=2 (1S; 1Q)) and supporting safe, effective, and up to date practice (F1=6 (2S; 4Q), F2=3 (2S; 1Q)). Also, 11 participants acknowledged that the NMC monitors professional development as a professional requirement (F1=8 (4S; 4Q), F2=3 (2S; 1Q)). These results confirm the view that, to achieve high standards of care and meet professional standards, professional development is important.

4.3 Differences across Factor 1 (F1) and Factor 2 (F2)

Alongside consensus, there were also conspicuous differences in F1 and F2 FA and TA results. These differences focused predominantly on the impact of organisational issues on compassionate care and will now be presented.

4.3.1 Factor 1 (F1) – Factor analysis results

Factor title: *There are challenges, but we are working to achieve compassionate care together.*

In the F1 FA, the explained variance was 34% and the eigenvalue was 10.3174. In total, 13 participants had commonalities that developed this factor. Six participants were student nurses (S2, S5, S6, S10, S13, S14), and seven participants were qualified nurses (Q3, Q4, Q5, Q8, Q9, Q10, Q12).

F1 is differentiated from F2, as participants strongly agreed that their managers, leaders, and mentors were instrumental in enabling compassionate care. For example, distinguishing statements for F1 are *Managers must be visible role models showing compassion* (13: +5)*; My manager/mentor supports me to learn from examples of excellent care* (30: +4)*;* and *Ward leadership has enormous impact on the quality of compassionate care provided by team members* (45: +4). In the RS feedback five qualified nurses (F1) commented that leading by example was important in supporting the nurses of the future. In the RS feedback, all the student nurses identified that mentors act as role models, supporting their learning. Collectively, participants were indifferent to the view that organisational values (3:0) and organisational targets (27:0) presented a barrier to compassionate care. They viewed the organisational culture as building trust and honesty (43; +3). The benefits of this were identified by participant Q3 in the RS feedback as promoting "confidence in patients and enhanc[ing] their patient experience." Managers and leaders were

viewed as providing support that helped participants to address and overcome challenges to compassionate care giving.

Collectively, participants in F1 strongly disagreed that time constraints (12: -4), increased workload (21: -2) or negative treatment towards them in clinical practice (31: -3), would not result in lower standards of care. The importance of maintaining standards of care was aligned to the strong agreement that demonstrating compassionate behaviours influences patient outcomes positively (44: +5). This view was captured in RS feedback, “care given with compassion positively affects the building up of rapport and trust between the patient and the nurse” (S14), “[patients] will open up to you and you positively impact on their journey” (Q12). RS feedback from participants emphasised the importance of the quality of care provided (F1=4 (3S; 1Q)) because “even if the patient has had more time with the nurse [this] does not mean other patients are not receiving good care” (S14). Also, participants identified the importance of a holistic approach to care giving (22: -3). This view is captured in feedback from participant S10, “physical care on its own is not more important than the way you could make someone feel… because both impact on the quality of care”. Also, F1 participants shared the view that, regardless of the knowledge and skills of others, they could still maintain high standards of care (14: +4), recognising their own responsibility in care giving.

Participants shared the view that their experiences, personal beliefs, values, and actions should not impact on the standard of compassionate care provision. There was strong disagreement that a longer time spent working in practice (20: -5), their regard for the patient (10: -4), sharing the same background or culture as the patient (19: -3), or unfair treatment from others (6: -3) impacted negatively on the provision of compassionate care. When collaborating and interacting with the patient, participants

across both factors assigned little importance to the suggestion that undercurrents in the workplace (15: -2), would change their behaviour towards patients. Participants did not have a particularly strong view about the acceptability of humour in the nurse-patient relationship (7: +2). However, boundaries in the relationship were identified as participants strongly disagreed that it was acceptable for issues from their personal life to influence compassionate care provision (5: -5). Added to this was their shared indifference to the suggestions that their own life experiences of distress meant they care more effectively for the patient (25: 0). In the RS feedback participants expressed the view that the way they dealt with distress might not always be appropriate to others, as individual experience and interpretation of distress is very different from person to person.

There was consensus across F1 and F2 that compassion cannot be taught. However, F1 participants said that more knowledge helped them become more compassionate (33: +3), and in the RS feedback knowledge was associated with learning from clinical practice experience. Examples from the RS feedback include “to learn about compassionate care nurses require education, experience, and exposure” (Q8) and with more “understanding… can offer support, advice and empathise… be compassionate” (Q4). When relating this to recruitment practices in nursing, F1 participants shared the view that “recruitment of already compassionate individuals ensures compassionate care” (48: +3). This is reflected in RS feedback from participant Q10 that, “nurses do have some element of compassion before they begin nursing”.

4.3.2 Thematic analysis results (F1)

Organisational issues

Working together to overcome work-based pressures - Participant feedback in the TA further affirmed the FA results, that "supportive ward leadership has a massive impact on staff" (Q10). Participants identified that leaders, managers and mentors help individuals to achieve compassionate care through role modelling (F1=11 (6S; 5Q) and showing compassion to patients and to staff (F1=10 (4S; 6Q)). Participant S6 said this positively influences "the morale of the team", and if "your door is open so that [nurses] can come and speak to you… then [they are] more likely to carry on with compassionate care" (S6).

Of the seven qualified nurses, six identified that they had attended and valued compassionate leadership training. Participant Q9 said the training emphasised the importance of "role modelling [as this] offers both the leader and staff learning opportunities" (Q9). Participants highlighted that they were able to integrate and apply elements of the training to their practice and this also contributed to their decision making. One participant (Q12) held the role of staff nurse and had not attended in-service leadership training.

All the participants in the F1 TA indicated that compassionate care positively influenced the patient experience. Participant Q4 suggested, "if the patients feel they are cared for they are going to relax more… trust you… respond to treatment better". Participant S13 highlighted the positive impact nurses have when "the patient is at the heart of care and providing compassionate care is what our main aim is".

To support the provision of compassionate care, it was identified that "a good nurse environment is essential (S13). Participants recognised that pressures such as increased workload (F1=5 (2S; 3Q)), paperwork (F1=2 (1S; 1Q)), and reduced staffing

levels (F1=3 (1S; 2Q)) can leave them feeling “emotionally drained” (S14). However, they believed these, “should not affect the nurses in providing compassionate care” (S14); “we have to reach certain targets, but it doesn’t, shouldn’t stop compassionate care’ (Q10); “I don’t think saying we are short staffed, or we are busy should be an excuse… it shouldn’t be, it just might take a bit longer” (Q5). Participants contextualised this in their feedback, for example:

> nurses put in extra time erm… to achieve that compassion, they will miss breaks because they are doing something with a patient, they will stay late and make sure everything is done…and they don’t get paid for it so obviously the service is running on goodwill.” Q8

The negative impact of relying on the goodwill of nurses to work longer hours is seen in the TA results. Of the seven qualified nurse participants, one participant “left the clinical area cos I was still striving to do the best I could, but I got so frustrated with all the paperwork and things, not having the time for people” (Q5). Additionally, participant Q4 stated “you can get burnout inevitably when you are dealing with people all the time… I’ve been through it myself… when [patients] were telling me things and I’d think yeah I don’t really care right now”. Participant Q4 added that she had to realise “rather than carrying on you need to recharge the batteries… to refuel every now and again… we are humans at the end of the day we are not bloomin’ angels or gods.”

Personal/relational issues

Personal feelings should not influence compassionate care provision **-** The TA results reflected the view that the personal feelings of participants should not influence compassionate care provision. Examples of actions towards patients that they believed were unacceptable included demonstrating “dislike” (F1=9 (6S; 3Q)) or being

"brusque" (Q5), "angry" (S10), or showing "personal preference" (F1=2 (1S; 1Q)). Participants also cited their professional responsibility of "a duty of care" to protect patients regardless of external influences or the actions of others (F1=10 (5S; 5Q)). Unprofessionalism was associated with "sharing [patients] personal information" (F1=3 (2S; 1Q)), disclosing any information without patient consent (F1=5 (3S; 2Q)), or "harming" a patient (F1=5 (3S; 2Q)).

Positive impact of compassionate care giving on patient and nurse - Participants in the F1 TA said they were motivated by the desire to help patients and they gained satisfaction from demonstrating altruistic behaviour. Participant Q4 captured this in the statement "caring for someone and seeing their smile, or seeing them feel better, that's worth loads." An orientation to reciprocity was also evident, a mutual or cooperative interchange with a sensitivity to the behaviours and attitudes of others. Participants identified the importance of treating others as you would wish your relatives, or yourself, to be treated (F1=9 (4S; 5Q)). Participants also identified more strongly in the TA that humour could be used positively (F1=8 (3S; 5Q)). This included connecting with the patient and helping them to relax.

Educational issues

Recruitment practices can contribute to compassionate care - From the TA results, eight participants identified that exploring existing skills and knowledge related to compassion (F1=8 (4S; 4Q)) and that valuing the life experiences of applicants (F1=2 (2Q)), could support recruitment practices. Participants were also aware, when recruiting individuals, that "it's not until they get out on the ward" (S2) that they are exposed to the reality of practice (F1=4 (2S; 2Q)). Consequently, "offering people more work experience" (Q5), may "contribute to recruitment and retention" in nursing

(S6). A pre-existing understanding of compassion could be identified through recruitment processes, and then cultivated.

4.3.3 Factor 2 (F2) – Factor analysis results

Factor title: *Organisational targets and workload pressures result in lower standards, limiting the provision of compassionate care.*

Results from F2 FA gave an explained variance of 7%, and their eigenvalue was 1.9768. In total, five participants had commonalities that developed this factor. Four participants were student nurses (S1, S4, S11, S12) and one participant was a qualified nurse (Q13).

Participants in F2 strongly agreed that the organisation was focused on meeting targets and that, accompanied by increased work-based pressures, this impacted negatively on compassionate care provision. This is evidenced in the distinguishing statement that *Organisational targets get in the way of compassionate care* (27: +4). To compound this, they strongly disagreed that senior managers helped them to understand organisational objectives (40: -4). This resulted in participants' indifference to the statement that the organisational culture in which they worked builds trust and honesty (43: 0).

F2 participants were much less convinced than F1 participants of the positive impact that managers and leaders had on the provision of compassionate care (13: 0; 30: +2, 45: -2; 46: 0). When considering support from management, participant S1 stated in RS feedback that "senior management are too busy in their own job role to offer support… they assume you should know what you are doing, and you see them when things go wrong". Participants suggested that "managers are producing more targets, creating more hurdles in the way of day-to-day care, making their targets more of a

priority than patient care" (S1); they are focusing "more on financial gains, on time frames… more than the individual" (Q13); and "staff are taken for granted and feel like a number" (S12). This was compounded by the lack of clarity around team roles and responsibilities (49: -3).

The strong orientation of F2 participants to the negative impact of time constraints and work-based pressures is captured in the distinguishing statement, *When work is busy standards of care are inevitably lower* (21: +5). This was reinforced by strong disagreement that there were readily available opportunities to discuss and reflect on issues in practice (47: -4). Also, participants shared low regard that demonstrating compassionate behaviours influenced patient outcomes positively (44: +2). In the RS feedback from participants, the impact of time constraints was evident – "ward areas are always too busy" (S4); "there is constant pressure and stress" (S2); "care becomes more task orientated" (Q13); and there is "a worry that we lose sight of compassion" (S4).

Nevertheless, there was shared disagreement from participants in the FA that their own personal safety was their main priority (39: -3) when engaging with patients. There was strong agreement, however, that there are limits to their capacity to provide compassion (51: +4).

In FA results, participants shared the view (37: -4) that feedback from colleagues does not help them to overcome negative attitudes they may have. From the RS feedback, individual participants related this to the way feedback is provided. Participant S12 stated,, "dependant on who gives the feedback and in what way the feedback is given, this can be pro or con" and participant S11 said of mentors ""it depends on the skills of the mentor, how busy they are, they may sign off competencies but never sit down and talk or share examples of compassionate care". S11 added that time constraints

mean that “you may work with HCAs [health care assistants]” rather than qualified staff (S11).

Participants strongly agreed that their own experiences of personal distress had contributed to their ability to care more effectively (25: +4). Sharing feelings and showing personal emotions were viewed positively (8: +3) and not seen as unprofessional (4: -4). Participants viewed their experiences as helping them to create a rapport and understanding with patients. This view is reflected in RS feedback **–** “that feeling of knowing someone’s been there too means a lot to some people” (S1) and “we are seen as being more human when emotions are shown, such as compassion” (S12).

Also, participants disagreed that demonstrating personal feelings was unacceptable to colleagues (9: -3). Participant S1 gave examples that “positive approaches… a smile on your face… showing compassion to colleagues, relatives and those around you helps to maintain compassionate care.” The value of integrating humour into the patient encounter was recognised as extremely positive. For example, a distinguishing statement for F2 was *It’s OK to use humour with patients* (7: +4). Participant S4 suggested that humour “can have a massive effect on how patients perceive the care provider”, with participant S11 offering a limitation “as long as it is light-hearted and doesn’t cross professional boundaries.”

Participants in F2 were indifferent to the view that undercurrents in the workplace (15: 0), the values of the organisation (3: -2) or the values and behaviours of the team they work with (29: 0) would change their behaviour towards patients. Participants agreed that sharing the same background or culture (19: +3) and liking the patient (10: +2) made it easier to provide compassionate care. Further insight was provided in feedback from RSs, as participant S4 stated: “when we relate to patients, understand

where they are coming from, it helps". Participant Q13 stated, "connecting with the patient through similar background or understanding their culture means I can respond to their individual needs" (Q13).

When reflecting on the impact of the nursing course on their practice, participants shared the view it did not prepare them for the long term demands of practice (50: +3). Participants also demonstrated low regard for the idea that with more knowledge they become more compassionate (33: -2). Nevertheless, participants in F2 shared the view that nursing education had equipped them to challenge uncompassionate practice (54: +3). Participant S1 said it "has given confidence… [and] knowledge of how to manage it".

4.3.4 Thematic analysis results (F2)

Organisational issues

Organisational targets and increased ward-based pressures result in lower standards - The results from the TA supported the FA results showing that work-based pressures and time constraints "get in the way of compassionate care" (Q13); "the busier you are the less time you have to spend with patients therefore care is going to be affected" (S4). Participant feedback identified that organisational targets intensify this pressure **–** "we are concentrating too much on them, making sure targets are met, ticking boxes. Inevitably compassion is going to be neglected" (S4). Additionally, the negative impact of inadequate staffing levels, excess paperwork, and time constraints were raised by all participants. Participants in F2 TA strongly acknowledged the positive impact on the patient of demonstrating compassionate care (F2=5 (4S; 1Q)). However, they said that, without the necessary time, they missed behavioural cues from the patient and this impacted on both relationship building and the standards of care they could provide. Participant Q13 said "if you were to sit down

with (the patient) longer and didn't have to fill out, like a tick box exercise with the admissions…you could probably pick up on cues… and build a rapport with them and they are more likely to express their concerns with you… [it] comes down to have you got time". Participants identified their concerns because of these pressures **–** "you do put yourself in situations that maybe you shouldn't to do best for your patient" (S4) and the resulting "stress will have an impact on how you are able to deliver compassionate care" (Q13). Consequently, participants shared the view that there were limits to the compassion they could give, even though they wanted to provide it.

All F2 participants in the TA reflected on the negative media attention driven by failings in healthcare provision and the "publication of the Francis Report" (F2=3 (2S; 1Q)). This was evident in feedback from participant S4. The findings were "shocking and unacceptable, and we need to be addressing bad practice" (S4). Participant S4 added that "bad practice, uncompassionate practice, happens in every hospital, every health authority. It says a lot about the team. Unless the team are comfortable to whistle blow or address issues, then it will just carry on".

Managers need to be visible - From F2 TA results, participants recognised the importance of engaged and visible managers, though they did not witness this in practice. Feedback said that if managers and leaders had a more visible presence this would have a "positive impact" (F2=2 (1S; 1Q)) benefiting both staff and patients (F2=5 (4S; 1Q)). This might include acting as role models, "demonstrating compassion" (S4, S12) and "offering support through sharing experience" (Q13). Also, participant Q13 added that managers could help "ward staff understand… achieve organisational objectives." Participant Q13, a staff nurse, identified that they had not attended leadership training yet and she believed this would be valuable to support their practice.

Personal/relational issues

Experience is important in compassionate relationship building - Participants viewed both life and clinical experiences as strong influencers on the provision of compassionate care. These experiences helped them to support patients in difficult situations (F2=4 (3S; 1Q)), contributing to compassionate relationship building. Participants also viewed demonstrations of personal emotions as acceptable and not unprofessional (F2=4 (3S; 1Q)) as these might be "good emotions, positive" (S11), such as "happiness" (F2=3 (3S)) or "showing empathy" (F2=3 (3S)). However, they did not agree that sharing personal issues was acceptable, as this might add to patient concerns (F2=4 (3S; 1Q)). Also, "showing dislike" (F2=4 (3S; 1Q)) towards a patient was unacceptable. Participant S4 identified that this is not always easy and likened nursing to "a stage show, sometimes you are so tired… you have to have a smile on your face as an approachable person; sometimes it's hard".

The use of humour was endorsed by all participants as having a positive effect on relationship building. The impact is captured in a range of participant statements **–** "patients say it's nice to see you smile… 99% of patients like humour, they want that kind of informality" (S11); it "makes the patient more comfortable and they trust you, like you're on the same level" (S4). The impact of humour was also identified as having a positive impact on ward staff and on patient care as it "builds morale; a humorous ward makes for good care" (S11).

Educational issues

Classroom teaching does not connect with the reality of practice - Participants reflected on the difficulties of attempting to teach compassion in a classroom setting as the teaching does not necessarily connect with the reality of practice. This is captured in the statement from participant S11 **–** "in the classroom it's… this is how it

should be… but when you are out in practice its nothing like it." Participant views reflected a need to connect experiences in practice to the development of understanding of compassionate care , as "you only learn when you do" (Q13). Four participants identified that knowledge is important, although they added that more knowledge does not necessarily equate to increased compassionate care (F2=4 (3S; 1Q)). Participant Q13 provided further insight, stating

> when you develop your knowledge within a certain area of nursing… it doesn't mean that you can be compassionate with it, because you can't just learn compassion, cos it's quite subjective I think to the individual and the person receiving it. It develops with experience.

4.4 Summary of all findings

The factor analysis has revealed consensus and differing viewpoints across factors. The thematic analysis has confirmed and extended understanding through the analysis of additional qualitative data.

There was consensus about the importance of communication and collaboration in compassionate relationship building. There was also consensus about the origins of compassion and the view that it cannot be taught. In contrast, the impact of organisational issues on the provision of compassionate care was viewed very differently across F1 and F2. To contextualise the findings, the participants contributing to F1 included 6 student nurses and 7 qualified nurses and the participants contributing to F2 included 4 student nurses and one qualified nurse (Table 8). The demographics of the student nurses indicate there were similar age ranges across F1 and F2, except for one student nurse aged 54 years who contributed to F1.

The 7 qualified nurses in F1 had an age range of 27 to 62 years, and a mean age of 45 years. The years of clinical experience range from 5 to 32 years. Six participants occupied senior roles, and one participant was a staff nurse. Only one qualified nurse (participant Q13) contributed to F2 results; Q13 had been qualified for three years. The impact of organisational issues on the provision of compassionate care was viewed very differently across F1 and F2. Compared to all the other qualified nurses, participant Q13 had the least experience (3 years) and this may have contributed to the difference in views.

Participant views of the issues that promote and inhibit compassionate care have been revealed. The issues identified in the findings also align to the three categories identified in the ILR: *Personal/relational issues, Organisational issues*, and *Educational issues*. These findings will be discussed, extended, and critically appraised in the next chapter.

Chapter Five – Discussion of findings

This research has investigated the views of nurses on compassionate care, its promoters and inhibitors, and how they maintain its provision. Sumner's (2008a) MCCNCAT has been applied as the theoretical framework. The use of Q methodology has revealed the subjective viewpoints, perceptions, and interpersonal relationships involved. The research findings support and augment existing literature illuminating how nurses negotiate the complexities of compassionate care provision. This chapter offers a discussion of the findings for the four research questions posed.

1. What are the views of nurses about compassionate care?
2. For nurses, what factors promote compassionate care?
3. For nurses, what factors inhibit compassionate care?
4. How do nurses achieve and maintain compassionate care?

Three overarching themes were identified from the ILR: *Personal/relational Issues: Organisational issues* and *Educational issues*. The findings from the research aligned with these overarching themes and will structure the discussion. Results from both the FA and TA identified consensus, but also differences in participants' views of the impact of organisational issues on the provision and maintenance of compassionate care. The differing views were captured in the factor titles and the overarching theme of *Organisational issues* and will be presented first. Participants in F2 viewed the organisation as a barrier to achieving compassionate care. In contrast, participants in F1 viewed the organisation as working with them to overcome barriers to compassionate care.

The overall results from F1, of both the factor analysis (FA) and thematic analysis (TA), suggest a high level of consistency between student nurses and qualified nurses in

their understanding of compassionate care and do not appear to be influenced by the role of participants, whereas F2 included 4 student nurses and one qualified nurse (Q13). There was an imbalance in roles, but due to small numbers it is not possible to state with certainty the level of consistency and the influence of role on participants' understanding of compassionate care.

The structure and abbreviations used to present the findings from the factor analysis and thematic analysis are presented in Table 10.

5.1 Organisational issues

5.1.1 Factor 2 (F2): *Organisational targets and workload pressures result in lower standards, limiting the provision of compassionate care*

In the results from F2, FA and TA strongly reflected the concern of participants that focusing on meeting organisational targets created a *conveyor belt* approach to compassionate care. This focus impacted negatively on compassionate care (27: +4) and resulted in lower standards (21: +5). Participants related this to work-based pressures, time constraints, inadequate staffing levels, and excess paperwork. Participants in the F2 TA strongly acknowledged the positive impact on the patient of demonstrating compassionate care (F2=5 (4S; 1Q)). However, they said that, without the necessary time, they missed behavioural cues from the patient and this impacted on both relationship building and the standards of care they could provide. Research has linked staff shortages to failures to attend to detail and poor communication between professionals, patients, and carers (Bramley & Matiti, 2014; Papadopoulos *et al.,* 2016a). The NHS Long Term Plan (2019, p.91) acknowledged the burden of paperwork on NHS staff. The NHS Plan said that staff would be supported "to capture all healthcare information digitally at the point of care… to reduce administrative

burden". Furthermore, NHS staff would be supported "to develop the digital skills they need to make effective use of tools and mobile access to digital services" (NHS Long Term Plan, 2019, p.94). However, the looming challenge is how organisations can introduce further technology, with the training required, amid ever increasing demands and constraints. This challenge is made evident, in the shared view of participants, that there is a lack of opportunity to discuss and reflect on issues in practice (47: -4).

Ward based pressures and a focus on targets were further compounded by a lack of support from senior management to help them to understand and achieve organisational objectives (40: -4), and by unclear team roles and responsibilities (49: -3). Participants did not view the organisational culture as building trust and honesty (43: 0) and strongly agreed that there are limits to the compassion they can give to patients (51: +4). Participants in the F2 TA results identified that nurses feel "battle worn" (S1), as they "try to spend an adequate amount of time with patients, but it can be difficult because of… the stresses that are on a ward environment" (S11). Literature has reported the negative impact on compassionate care of focusing on metrics, efficiency, and financial savings to meet targets (de Zulueta, 2016; Sinclair *et al.,* 2016a; Babaei and Taleghani, 2019).

In the F2 FA results, participants were much less convinced of the positive impact that managers and leaders have on the provision of compassionate care, in offering support and as visible role models (13: 0; 30: +2; 45: -2; 46: 0). In the F2 TA results participants said that if managers and leaders were more visible this would have a positive impact. Research supports the positive impact when management visibly reflects the organisation's core values and vision in its actions (MacArthur *et al.,* 2017). Increased visibility also provides the opportunity for management to experience the reality of practice and this can support decision making (Berwick, 2013).

There was recognition in the FA and TA results that when staff are kind to each other, this impacts positively on the provision of compassionate care (28: +2). In the TA results, participant S12 stated “when you have compassion for other people that you are working with then you’ve got more compassion for your patients” (S12). However, in contrast there was strong disagreement that feedback from colleagues was helpful (37: -4). Feedback from the RSs said that this was related to the skills of the mentor and to time constraints. Participant S11 identified time constraints as meaning that “you may work with HCAs [health care assistants]” rather than qualified staff. Curtis, Horton and Smith (2012) said that students witnessed qualified nurses delegating caring activities, reducing their interactions with patients and opportunities to understand the patients’ experiences. This socialisation in practice can result in dissonance between the student’s professional ideals and the reality of practice and students manage this by balancing and adapting their ideals to conform to constraints (Curtis, Horton, and Smith, 2012). This can eventually impact negatively on the behaviour of staff, resulting in uncompassionate care (Sumner, 2008b; Horsburgh and Ross, 2013; Bramley and Matiti, 2014).

As already identified, participants shared a view on the limited opportunities to discuss issues in practice (47: -4). Horsburgh and Ross (2013) reported that, rather than receiving structured support, nurses often found that support in practice was reliant on the goodwill of staff. Practice-based socialisation impacts on the experiences of nurses and there is an ongoing risk that if nurses do not witness the enactment of supportive, compassionate practice through role modelling, they may not realise its value to the patient and to themselves. Kornhaber & Wilson (2011) also suggest that resilience can be developed when cohesive working teams provide emotional support through opportunities for reflection.

Nevertheless, participants viewed the patient's needs as their priority, rather than their own personal safety (39: -3). In the TA results F2 participants identified that, even when faced with constraints outside of their control, their personal motivation and commitment made them want to provide the standard of care they believed patients deserve.

To add to the pressure on the role of the nurse, since the final data collection phase of this research, coronavirus (COVID-19) has created a worldwide health crisis, and been declared a pandemic by the World Health Organization (WHO 2020). When caring for patients, nurses are confronted with greater risk of exposure to the disease, extreme workloads, time constraints, moral dilemmas, and a rapidly evolving practice environment (Shanafelt, Ripp and Trockel 2020). A Kings Fund report entitled 'The courage of compassion, supporting nurses and midwives to deliver high-quality care' (West, Bailey and Williams 2020) and a longitudinal study by the Royal College of Nursing (RCN Research Society 2020) identified that the pandemic has further exacerbated chronic excessive work pressures. West, Bailey and Williams (2020) concluded that the provision of compassionate care will be further challenged.

Sumner (2008a, p.100) stated "nurses demand much of themselves", and compassionate relationship building results in vulnerability for both the nurse and the patient. More than ever in the context of COVID-19, participants place their own personal safety second to patient needs, and the effect of striving to maintain standards without appropriate support can be profoundly negative (Chou, Hecker and Martin, 2012; Grandey *et al.,* 2012).

Sumner (2008a, p.242) said that, when engaging in bi-directional communication, nurses reveal their personal selves, enabling the "compassionate, kind self or human vulnerable side of the nurse to surface, but at the same time this can be hurtful and

draining of [their] existential core". Gilbert (2010) viewed our emotions as regulated by systems. The *soothing and contentment system* (Gilbert, 2010) is designed to achieve contentment and a feeling of safety, and for nurses to practice compassionately they need to feel content and safe (Gilbert, 2010). Therefore, when nurses experience negative emotions, they seek support from managers, leaders, and colleagues (Dewar and Christley, 2013), attempting to balance their emotions drawing on the *threat and protection system*. If support is not available, imbalance occurs between the emotional regulation systems and Bridges *et al.,* (2013, p.767) suggest that this can lead nurses to employ "strategies to actively disengage" from relationship building to protect themselves, due to the impact of emotional labour.

Sinclair *et al.,* (2017b) emphasised that the physical, emotional, social, and spiritual health of healthcare providers is impaired by cumulative stress related to work, impacting on compassionate caring, and interpersonal relations (Fry *et al.,* 2013; Sinclair *et al.,* 2017b). The demands and emotional toll placed on nurses are recognised in the literature as 'emotional labour' (Hochschild, 1983; Smith, 1992) and 'compassion fatigue' (Sabo, 2006; Hunsaker *et al.,* 2015). The emotional labour required as they strive to maintain standards and meet organisational demands, is captured in the statement from participant S4, "…sometimes nursing, it's like a stage show… you have to have that smile on your face, as an approachable person; sometimes it's hard." This reflects the view that nurses may participate in "surface acting," regulating their own emotional reactions by following "organizationally prescribed display rules" regardless of their own feelings (Bagdasarov and Connelly, 2013, p.126). When there is a mismatch between inner emotions and expected emotions this can result in emotional dissonance which leads to emotional labour (Msiska *et al.,* 2014). As nurses engage in high levels of emotional labour, they are

at risk of becoming demotivated and emotionally detached, burnt out or emotionally exhausted (Sabo, 2006; Firth-Cozens and Cornwell, 2009; Burtson and Stichler, 2010; Hunsaker *et al.,* 2015; Babaei and Taleghani, 2019).

Sumner (2008a) identified that building compassionate relationships is demanding and requires recognition of the nurse's emotional endeavour. "Staff well-being structures and practices" can sustain compassionate practice (de Zulueta, 2016, p.2). Hunsaker *et al.,* (2015) add that managers who communicate effectively and offer support and counselling engender higher levels of compassion satisfaction and lower levels of burnout. McAllister (2013, p.58) agrees that nurses must be prepared for the emotional labour required of them, and resilience may be a "personal, social and cultural strategy for surviving and even transcending adversity." Participants in the F2 FA strongly viewed their own experiences of personal distress as enabling them to care more effectively (25: +4). The F2 TA results suggested participants' maturity and associated life experiences helped them to overcome adversity (F2=3 (2S; 1Q)). Sumner (2010) agrees that the nurse's degree of inner resilience is influenced by their lifelong values, beliefs, and experiences. Consequently, developing resilience can support nurses and improve their wellbeing (Stephens, 2013).

Participants in the F2 FA viewed the use of humour with patients as positive (7: +4). In the TA results it was recognised as contributing to compassionate relationship building and working relationships with colleagues. It reduced stress in clinical situations, enhanced positive patient perceptions of the nurse, contributed to positive working relationships with colleagues and helped the patient to relax. The use of humour has also been identified as a strategy to provide relief from stress (Cameron and Brownie, 2010).

The Willis report (2012) suggested nurses do not always care for themselves, and Sumner (2006, p.11) proposed that "In order to meet individual vulnerabilities and needs; one must care for self before one can care for other''. Moreover, Sinclair *et al.,* (2017a) suggests that self-kindness and self-care strategies are essential. The nurse must demonstrate self-compassion (Dewar and Christley, 2013; Papadopoulos *et al.,* 2016a). Self-compassion includes being kind and understanding towards oneself, having increased awareness of one's own negative thoughts, avoiding self-criticism, and practising self-acceptance (Sinclair *et al.,* 2017c). Also, receiving compassion from others enhances self-compassion (Sinclair *et al.,* 2017c). By facilitating resilience, individual reactions to negative events can be moderated, and this is required for nurses to positively adjust and thrive in an environment of adversity (Curtis, Horton, and Smith, 2012).

5.1.2 Factor One (F1): *There are challenges, but we are working to achieve compassionate care together*

Participants in F1 FA shared the view that time constraints and increased workload were not associated with a lowering of standards (12: -4; 21: -2). However, in the TA results individual participants identified that as they strive to maintain standards against a backdrop of increased work pressures, there are negative consequences. In the TA results, participants revealed that increased workload (F1=5 (2S; 3Q)), paperwork (F1=2 (1S; 1Q)), and reduced staffing levels (F1=3 (1S; 2Q)) left them feeling "emotionally drained" (S14). Participants said that, to meet work-based demands, "nurses put in extra time… miss breaks… stay late and make sure everything is done… and they don't get paid for it, so obviously the service is running on goodwill" (Q8). Research has identified that nurses go above and beyond to meet the patients' needs (van der Cingel, 2011; Bramley and Matiti, 2014; Kneafsey *et al.,*

2015). Dixon-Woods *et al.,* (2014) reported that the number of nurses working paid extra hours has decreased consistently but, since 2009, the number working unpaid extra hours has increased sharply. Wheatley (2017) suggested that nursing overtime is common despite evidence that it increases the incidence of patient and nurse adverse events.

By attempting to override their emotional regulation systems (Gilbert, 2010), not responding to threat, or seeking to protect themselves and make themselves safe, participants are in fact placing themselves at risk. In the F1 TA, two participants acknowledged the profound impact of work-based pressures. Participant Q5 left the clinical area due to frustration with excess paperwork and time constraints. Participant Q4 reported experiencing burnout and acknowledged vulnerability because of work-based demands. Sumner (2008a, p.215) suggests that nurses, from the beginning of their nurse education, are "imprinted with the moral obligation to care for the patient, and at times this may be at expense of her [sic] own needs". Hunsaker *et al.,* (2015) suggest that improving recognition and awareness of compassion satisfaction, compassion fatigue, and burnout in nurses may prevent emotional exhaustion.

In contrast to F2 participants, those in the F1 FA did not view the organisational culture as a barrier to compassionate care. Rather, they viewed the culture as building trust and honesty (43: +3). Dixon-Woods *et al.,* (2014) found that a positive organisational culture includes ensuring staff feel safe, supported, respected and valued at work and this impacts positively on the provision of compassionate care. Participants in F1 FA were indifferent to the view that the organisation was focused on achieving targets (27: 0), and that organisational values conflicted with their own values (3: 0). The view that time constraints and increased workload were associated with a lowering of standards was clearly dismissed (12: -4; 21: -2). Participants identified that the quality of care

provided (F1=4 (3S; 1Q)) and how you “make someone feel” (S10), were more relevant than the time spent with them. Research has identified that small acts, or gestures contribute to compassionate care and have been identified as going above and beyond to meet the patient’s needs (van der Cingel, 2011; Burnell and Agan, 2013; Bramley and Matiti, 2014; Kneafsey *et al.,* 2015). Behaviours such as smiling, appropriate touch, and eye contact have been identified as contributing to relationship building and the quality of care given (Fry *et al.,* 2013; Kneafsey *et al.,* 2015).

In the FA results, F1 participants were strongly oriented towards the view that managers and leaders were instrumental in enabling compassionate care. This was achieved through visibly sharing their skills and knowledge and showing compassion to others (13: +5; 30: +4; 45: +4). This support is further evidenced in the results from F1 TA as participants said they witnessed their managers showing compassion to patients and to staff (F1 = 10 (4S; 6Q)). Research confirms that enablers to compassionate care include visible role models, sharing their knowledge and skills (Dewar and Nolan, 2013; Horsburgh and Ross, 2013; Hunsaker *et al.,* 2015; Christiansen *et al., et al.,* 2015; Jones *et al*. 2016; Singh *et al.,* 2018; Babaei and Taleghani, 2019). Reports by Francis (2013) and Keogh (2013) suggested, that to be able to sustain the future NHS, organisations must have the right leadership, not only to remain financially viable but also to deliver compassionate and quality care for patients.

Strengthening compassionate leadership enables the delivery of compassionate care, nurturing a positive environment and actively involving staff and patients (Dewar and Nolan, 2013; NHS 2014b), contributing to high quality care and a positive patient experience (DH, 2017; de Zulueta, 2016). Compassionate leadership has been advocated by NHS England (2014a, 2014b), and the Health and Social Care (HSC)

Collective Leadership Strategy (DH 2017). Both promote the values and behaviours associated with compassionate care and this has been found to contribute to staff wellbeing (O'Driscoll *et al.,* 2018). Also, experiencing compassion makes people better able to show compassion to others (de Zulueta, 2016; Papadopoulos *et al.,* 2016a, 2016b). The behaviour of compassionate leaders can include support and encouragement to nurses to practice reflection and develop self-compassion (Dewar and Christley, 2013). As McAllister and McKinnon (2009) and McAllister (2013) suggest that, through reflection, nurses can explore their own protective factors and share experiences of resilience and vulnerability.

To compound the impact of positive interpersonal relationships, participants in F1 FA and TA agreed that when staff are kind to each other, compassionate care is more likely (28: F1 +3). Collaborative and reciprocal interpersonal relationships with colleagues have been identified as enablers to compassionate care (Dewar and Nolan, 2013; Horsburgh and Ross, 2013; Hunsaker *et al.,* 2015; Christiansen *et al.,* 2015; Jones *et al.,* 2016; Singh *et al.,* 2018; Babaei and Taleghani, 2019). Ballatt and Campling (2011, p.3) suggest that "the promotion of kinship, connectedness and kindness between staff and with patients," alongside compassion, "should be actively nurtured" (p.66). Demonstrating compassionate behaviours was also viewed by F1 participants as impacting positively on patient outcomes (44: +5) and was not affected by the length of time they had worked in practice care (20: F1 -5). Studies have identified the importance of compassion to improved patient outcomes (de Zulueta, 2016; Braithwaite *et al.,* 2017) and enhanced patient wellbeing (Graber and Mitcham, 2004; Benner, Tanner and Chesla, 2009; Gilbert, 2010; Sinclair *et al.,* 2016b; Sinclair *et al.,* 2016d). Gilbert (2010) suggests that our *incentive and resource seeking system* motivates us to locate resources to help us to survive and prosper. When nurses

demonstrate compassionate behaviour, this has reciprocal benefits to both nurse and patient. It can alleviate distress and lead to contentment, coping, confidence, satisfaction and empowerment in the patient (Gilbert, 2010; Sinclair *et al.,* 2016b). It also acts as a motivator to the nurse enhancing the quality of the nurse-patient relationship supporting the provision of compassionate care.

F1 participants said that they witness role modelling of compassion to patients and to others, and research suggests this creates a "virtuous" circle or spiral (Ballatt and Campling, 2011, p.44; de Zulueta, 2016, p.2). If nurses experience compassion at work, they are more likely to be more compassionate to their colleagues and to the patients in their care (de Zulueta, 2016; Papadopoulos *et al.,* 2016a, 2016b). This satisfaction positively influences job performance as well as longevity within nursing (Burtson and Stichler, 2010; Hayward and Tuckey, 2011). Consequently, there are benefits to both the patient and the nurse.

5.1.3 Summary of the impact of Organisational Issues on the provision of compassionate care

It is evident from the contrasting results from participants in F1 and F2 that organisational culture can positively or negatively influence the provision of compassion-based care, and nurses' wellbeing. It is recognised that every organisation has its own culture, with shared values, assumptions, and beliefs, and this culture can differ in subgroups (de Zulueta, 2016). Student nurses experience varied placements and these experiences influence their view of the whole organisation. Qualified nurses may move across, and within, clinical specialisms. Both student nurses and qualified nurses work with a variety of colleagues. The values and beliefs of the organisation are interpreted and enacted by nurses, shaped by their practice experiences. When there is conflict between organisational values and

beliefs and the ability of nurses to realise them when confronted with increased demands and limited resources, the nurse experiences disillusionment and dissatisfaction. The contrasting results across F1 and F2 indicate that, within subcultures, the value placed on compassionate care differs. This is evident in the enactment of support by managers and leaders, the recognition of work-based demands and the investment of nurses in the provision of compassionate care. Also, culture and leadership are recognised as interdependent (de Zulueta, 2016; MacArthur *et al.,* 2017). To achieve a culture of compassion the organisation must invest in compassionate leadership training and provide the necessary resources to realise compassionate care.

de Zulueta (2016) identified the importance of training and well-being programmes in compassionate leadership development, as they support the delivery of compassionate care. Dewar and Cook (2014) developed a leadership programme in which nurses reflected on compassionate practices. This led to enhanced self-awareness of leaders and the development of creative ways of relationship building that influenced compassionate caring. The research findings across both factors identified that six of the total of eight qualified staff had engaged in compassionate leadership development, and all of these contributed to F1. The six qualified nurses (F1) occupied more senior roles, while the two participants who had not attended were staff nurses. Participants who had attended said it had contributed to their understanding of and support for compassionate care through role modelling. These results suggest that all qualified nurses, regardless of grade, should engage in compassionate leadership development, including newly qualified nurses onwards. This development should be planned over time, valuing and building on clinical experiences. Activities could be integrated to develop individual, team, and

departmental strategies to understand the promoters and inhibitors to compassionate care giving, and how such care can be maintained.

Participants from both factors identified the negative impact of lack of resources, inadequate staffing levels, and workload pressures on the provision of compassionate care. The National Institute for Health and Care Excellence (NICE)'s staffing guidelines in adult inpatient settings (NICE, 2014) and the Carter report (DH, 2016) issued guidance that healthcare organisations should ensure that staff are always present in appropriate numbers to provide safe care. However, participants across both factors had not observed the enactment of this guidance in their practice areas. It is important that nurses are enabled to practice with compassion and that employers recognise the time and resources required. Otherwise, as Sumner (2008a, p.100) suggests, when nurses are confronted by external constraints in practice over which they do not have control, when the system is failing them, "their humanness is unprotected" (Sumner 2008a, p.100). The negative impact of this will be visible in patient satisfaction and outcomes, nurses' wellbeing and longevity in nursing, and the organisation's reputation and viability.

Support mechanisms for nurses and recognition that compassionate care requires high levels of skill and support are essential. Strategies to support nurses include the development of a culture of compassion, visible demonstrations of support and compassion from managers and leaders, and the provision of appropriate resources. Without this support the negative impact of stress and emotional labour will potentially lead to emotional exhaustion, compassion fatigue and burnout. Supportive, collaborative and reciprocal interpersonal relationships with colleagues can help nurses manage emotional labour and promote effective care. Nurses must have the opportunity to share experiences of resilience and vulnerability, to practice reflection

and develop self-compassion. Also, the use of humour can offer relief and support to nurses and enhance collegial relationships.

5.2 Personal/relational issues

5.2.1 Nurse-patient communication and compassionate relationship building

All participants in both factors, in the RS feedback and TA results, identified the central role of communication in the process of compassionate relationship building. This included an explicit and intuitive awareness of the two-way communication between nurse and patient. This aligns with the critical component of Sumner's (2008a) MCCNCAT, the recognition of bi-directionality in nurse-patient communication. Sumner (2008a, p.6) stated the "nurse and patient are inextricably entwined in a relationship," the nurse brings their personal and professional self to the interaction and the patient brings their personal and illness self. The MCCNCAT incorporates three claims to normative validity (rational consensus) in communication. Two are represented by the *claim to truthfulness* (which is the intra-subjective self, including values and beliefs and emotional responses) and the *claim to rightness* (which refers to the intersubjective interaction or discourse that occurs between two participants). Sumner's (2008a) premise is that, because the nurse-patient interaction is communicative, both are inherently exposed and therefore vulnerable, requiring considerateness. It is the way the individuals participate in the interaction that offers the moral dimension, and Sumner (2008a) proposed, and tested theory (Sumner and Fisher (2008), that nursing is a moral, bi-directional activity between nurse and patient.

In the ILR, two frameworks (van der Cingel, 2011; Kneafsey *et al.,* 2015) and three models (Dewar and Nolan, 2013; Sinclair *et al.,* 2016c; Sinclair *et al.,* 2018) recognised the importance of communication in compassionate relationship building. However, the focus of communication was nurse to patient, with acknowledgement of the

inherent vulnerability of the patient in this process. Not fully recognised was the shared investment and interdependence of both nurse and patient, whereby “both the nurse and patient [are] giving and receiving in return,” resulting in both experiencing vulnerability (Sumner, 2006, p.9). The shared investment can also have benefits to both nurse and patient; it can be mutually rewarding, leading to growth and development, “validation and blossoming’’ (Sumner, 2006, p.11).

Feedback from the RSs and the TA results across both factors identified compassion as a value that underpinned care, when responding to the patient’s needs and potential suffering. Internationally, nursing regulatory bodies (Canadian Nurses Association, 2017; American Nurses Association, 2015; NMC, 2018a) identify compassion as a professional value. The CiPVS (DH, 2012c) identified the six values of caring as; care, compassion, competence, communication, courage, and commitment, referred to as the 6 C’s. Participants in my research supported these values but added kindness, empathy, dignity, respect, trust and being non-judgemental, thereby reflecting the professional standards required of nurses (NMC, 2018a). The Code (NMC, 2018a, p.6) states that nurses must uphold patients’ dignity by treating them with “kindness, respect and compassion”. Nurses must also “recognise and respect the contribution that people can make to their own health and wellbeing” and ensure “that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged” (NMC, 2018a, p.6), an explicit requirement that nurses maintain the patient’s dignity, demonstrate kindness and respect, recognise their legal rights and avoid being judgemental.

From the patient’s perspective Badger and Royse (2012) identified respect, communication and competence as valued in the provision of compassionate care. The promotion of “trust through professionalism” is identified by the NMC (2018a, p.5)

and Pellegrino (1995, p.267) sees the act of a profession as being "…an act of implicit promise making, that establishes a covenant of trust". Although the word empathy is not explicit in the Code (NMC, 2018a) the requirement for nurses to provide care with compassion is evident. Van der Cingel (2014, p.1254) suggests that empathy is an "ability that functions as a condition of compassion". Implicit in compassionate care, and in empathy, is working to understand the depth of another person's feelings and accurately acknowledge and "resonate emotionally with that feeling to some degree" (Post *et al.,* 2014, p.873). In summary, participants in both factors endorsed the six values identified in the government strategy aimed at developing a culture of compassion (CiPVS, DH, 2012c). Participants also illuminated six more values and these can be aligned to the professional values required of the nurse (NMC, 2018a).

5.2.2 Personal commitment, passion, and motivation to care

Participants across both factors in the TA results identified their personal commitment, passion, and motivation to care for others. This was captured in participant feedback, "as long as we know we are doing the best we can for the patient" (Q9); and "when we make the patient the priority, we give honest, compassionate, meaningful care" (S1). Tschudin (2003, p.8) stated "my own existence achieves its fulfilment or perfection by virtue of the way I care for others". Research has identified facilitators to the provision of compassionate care as personal systems of values and beliefs which included personal commitment (Adamson and Dewar, 2015; Christiansen *et al.,* 2015; Sinclair 2016c) and personal attributes, experiences, and motivation (Cole-King and Gilbert, 2011; Christiansen *et al.,* 2015; Sinclair *et al.,* 2016d; Strauss *et al.,* 2016; Singh *et al.,* 2018; Babaei and Taleghani, 2019).

Participants in F1, FA and TA, shared the view that their personal motivation and commitment was strengthened by their professional responsibility to provide

compassionate care. This was made evident in the shared view of F1 participants that, regardless of the knowledge and skills, or actions of others towards them, they would still provide compassionate care (14: +4; 6: -3; 31: -3). Participants in F1 TA said this professional responsibility applied regardless of external influences or the actions of others (F1=10 (5S; 5Q)). Actions deemed unprofessional included "sharing [patients'] personal information" (F1= (2S; 1Q)), disclosing any information without patient consent (F1=5 (3S; 2Q)), or "harming" a patient (F1=5 (3S; 2Q)). In law and ethics, nurses have a responsibility to provide care, to act as an advocate with a *duty of care,* to protect the interests of the patient and maintain professional competence (Thompson, Melia and Boyd, 2000). The NMC (2018a, p.3) says that the public can expect nurses to provide "safe, compassionate, and effective nursing care" and this requirement is enshrined in the NHS Constitution (DH, 2009), the Health and Social Care Act (2012) and the Care Act (DH, 2014). Participants in F1 strongly emphasised their professional responsibility to provide a compassionate experience for each patient. This was both a motivator and a contributor to their personal and professional satisfaction.

In contrast to indifference from F1 participants, participants in F2 FA were strongly oriented to the view that their own experiences of personal distress had contributed to their ability to care more effectively (25: F1 0; F2 +4). F2 participants viewed sharing feelings and showing personal emotions as positive (8: +3) and did not recognise this as unprofessional (4: -4) or unacceptable to colleagues (9: -3). This is reflected in RS feedback: "[nurses] are seen as being more human when emotions are shown, such as compassion" (S12), as the patients realise "someone's been there too" (S1). Consequently, F2 participants viewed their experiences and the sharing of emotions as helping them to create a rapport with patients.

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Participants in F2 referred directly to both the negative impact of failings in care provision publicised in the Francis inquiry (Francis, 2010, 2013) and the subsequent media attention. They viewed the findings as shocking and unacceptable and shared the view that poor practice should be addressed by nurses. Participants in the F2 FA shared the view that education had equipped them to challenge uncompassionate practice (54: +3). In the TA results, they added that clinical experience contributed to the importance of identifying concerns immediately and taking necessary action, exercising their professional *duty of candour* (NMC, 2018a). As participant S4 (F2)

stated, “bad practice, uncompassionate practice, happens in every hospital in every health authority. It says a lot about the team, unless the team are comfortable to whistleblow or address issues, then it will just carry on”. Participants in F2 readily identified actions that should be taken to provide protection for the patient.

Participants in F1 made less reference to the impact of negative media attention and their actions in response to poor standards of care. However, participants in the F1 TA identified the importance of treating others as you would wish your relatives, or yourself, to be treated (F1=9 (4S; 5Q)). From this commitment to altruistic behaviour they gained personal satisfaction, motivated by the desire to help patients. McAllister and Ryan (1996) suggest that the inter-relational consequences of a good act have a positive effect on the nurses’ characters and therefore such an act benefits them personally. As participant Q4 stated in the TA, “when you help someone, you get that feeling of goodness”. Altruism has been highlighted as voluntary behaviour not undertaken with the expectation of reward or punishment (von Dietze and Orb, 2000; Kneafsey *et al.,* 2015), however, the result can be a mutually beneficial relationship (Gilbert, 2010; Goetz, Keltner and Simon-Thomas, 2010). Compassion is thought to be an emotional antecedent to altruistic behaviour, the response of caring for and wanting to relieve suffering (von Dietze and Orb, 2000; Goetz, Keltner and Simon-Thomas, 2010; Cole-King and Gilbert, 2011). Pellegrino and Thomasma (1993 p81) recognise compassion as one of the “caring or altruistic virtues” and Sinclair *et al.,* (2016c) suggest the nurse-patient relationship is augmented by the caregivers’ virtues.

Consequently, both factors identified their commitment to compassionate care and the behaviours and actions that enabled its provision. This was associated by participants in both factors with their professional responsibilities.

5.2.3 Collaborating to build a compassionate relationship

Collaborating with the patient and building a compassionate relationship of confidence and trust were viewed as significant by participants in F1 and F2. Building a compassionate relationship requires a willingness to engage and be affected by patient experiences (Strauss *et al.,* 2016). Participants across both factors in the FA recognised the need for emotional engagement with patients, strongly disagreeing that, to protect themselves from undue stress, they should distance themselves from the patient (23: F1 -4, F2 -5), or focus on physical care (17: F1 -3, F2 -3; 22: F1 -3, F2 -2). Participants across both factors also had low regard for, or were indifferent to, the view that undercurrents in the workplace (15: F1 -2, F2 0), the values of the organisation (3: F1 0, F2 +2), or the values and behaviours of the team they work with (29: F1 0, F2 0) would change their behaviour towards patients. Participants shared the view that building a compassionate relationship required the nurse to put aside external influences and create emotional resonance with the patient. Research has identified that not distancing themselves from the patient, and creating emotional resonance gives the nurse increased job satisfaction (Graber and Mitcham, 2004; Perry, 2009; Burtson and Stichler, 2010; Way and Tracy, 2012).

When engaging with the patient, F2 participants articulated a willingness to share their personal selves (8: +3). The skills involved in relationship building have been identified as getting to know the patient, feeling their suffering, identifying with and linking to patients, and a willingness to provide support to meet individualised needs (Sumner, 2008b; Graber and Mitcham, 2004; Badger and Royse, 2012; Kvangarsnes *et al.,* 2013). Sumner (2008a) said that, through communication and reflection on actions, the nurse interprets how their actions and behaviours are received by the patient. This investment contributes to a successful nurse-patient interaction. A result of this bi-

directional activity between the nurse and patient is that the patient requires consideration as their vulnerability is exposed; they require the nurse's "professional purposeful attunement" (Sumner, 2008a, p.200). Four of the five participants in F2 were student nurses completing an educational programme to become registered nurses. They are guided by professional standards and embodied values in The Code (NMC 2018a) that states nurses must promote professionalism and trust and: "be aware at all times of how your behaviour can affect and influence the behaviour of other people" (statement 20.3, p.18); and "treat people in a way that does not take advantage of their vulnerability or cause them upset or distress" (statement 20.5, p.18). Also statement 20.6 in The Code (NMC 2018a p.18) identifies nurses must "stay objective and have clear professional boundaries at all times with people in [their] care (including those who have been in your care in the past), their families and carers." Oversharing of self by student nurses in F2 may risk crossing those professional boundaries, burdening the patient with further concerns or changing the dynamics of the professional relationship. Sumner (2008a p.101) states "Professional detachment is needed for critical judgement and does not suggest lack of concern or compassion for the patient". Consequently, Sumner (2008a p.243) suggests "the nurse must learn how to harness and manage emotion in order to utilize it effectively in the discourse with the patient".

However, the interaction also results in vulnerability for the nurse and a requirement for reciprocal consideration (Sumner, 2008a). Compassion has been understood as an individual choice and a moral virtue (Pellegrino, 1995; Tuckett, 1999; Tschudin, 2003; Schantz, 2007), but once the nurse makes this choice, their vulnerability must be recognised and support given.

Participants acknowledged that, to achieve holistic care, communication and collaboration are required between different professions and with patients' relatives/carers. This is supported by research (Badger and Royse, 2012; Dewar and Nolan, 2013; Kvangarsnes *et al.,* 2013). Research outcomes from the LCCP included strategies to enhance collaborative working, involving a range of individuals. Dewar *et al.,* (2010) focused on emotional touchpoints, key points in the patient journey which were found to contribute to the development of effective and meaningful relationships between nurse and patient. Dewar and Mackay (2010) developed positive caring practice statements, from which action plans were developed to enhance compassionate care. Dewar and Nolan (2013) focused research on the development of appreciative caring conversations enabling collaboration between patients, carers, and staff to support emotional engagement in practice. All the strategies to enhance collaborative working, required engagement from the nurse and support from the organisation.

The value of integrating humour into the patient encounter was recognised as extremely positive by participants in the F2 FA (7: +4). In the TA results the participants said the incorporation of humour into their practice enhanced relationship building and collaboration with the patient. Participants said it reduces stress in clinical situations, has a positive impact on patient outcomes, and contributes to the working relationships with colleagues. Sumner (2008a, p.211) believes that when dialogue is "comfortable" it allows the person behind the role to emerge, contributing to trust and ongoing relationship building. Research has identified that behaviours such as smiling, appropriate touch, eye contact (Fry *et al.,* 2013; Kneafsey *et al.,* 2015) and humour (Burnell and Agan, 2013; Dewar and Nolan, 2013) contributed to relationship building, supporting emotional disclosure (Perry 2009). Bolton (2000, p.585) suggests

that “nurses supplement their emotional labour with humour as a way of easing tension.” However, F2 participants identified that humour must be used appropriately and with sensitivity, as reflected in feedback from participant S11 – “as long as it is light-hearted and doesn’t cross professional boundaries”. Tanay, Roberts and Ream (2013) highlight that before humour is shared, trust must be established and “constant assessment and reflection help ensure humour is used appropriately”.

5.2.4 Personal issues and judgements should not impact on compassionate care.

Participants across both factors strongly disagreed about whether it was acceptable to allow personal issues to influence compassionate care provision. This was evidenced in the FA results (5: F1 – 5, F2 -5) and in the TA results (F1=11 (6S; 5Q), F2=4 (S3; Q1)). In the RS feedback, participant S11 stated “I treat all patients with care and compassion regardless of what happens in my personal life” and participant Q8 added “patients have enough problems; they do not need to hear mine”. Sumner (2008a) suggested that “the nurse is able to reflect on her own behaviours and how they are perceived by the patient and is able to adjust them according to the particular situation” (Sumner 2008a, p.209).

Within the research findings, the interrelationship of compassionate care and the professional standards and values for nursing has been highlighted. In the provision of compassionate care, van der Cingel (2009) proposed that nurses must set aside their own interests, values and judgements. In the FA results, participants across both factors shared a view of the importance of avoiding judgement when providing compassionate care (24: F1 -4, F2 -3). This was also evident in the TA results (F1=11 (6S; 5Q), F2=4 (S3; Q1)). These views were captured in the TA feedback from participant S13 – “by avoiding judgements, with [the patients] needs being the centre

of care, then the nurse provides compassionate care". Nevertheless, participants recognised that challenges to compassionate care exist, such as personal feelings towards a patient. Participants in the F1 FA strongly disagreed that liking the patient would make compassionate care easier (10: -4), whereas participants in F2 agreed to some extent with the statement (10: +2). There was clarification in the F2 RS feedback. An example from participant S4 was, "when we relate to patients, understand where they are coming from; it helps". Nevertheless, participants in both F1 and F2 TA recognised that their personal feelings can be reflected in their actions towards patients. Participants said that unacceptable behaviour towards a patient was "showing dislike" (F1=9 (6S; 3Q), F2=4 (3S; 1Q)) or being "brusque" (Q5) or "angry" (S10). Sumner (2008a) suggests patients are affected by their illness situation and as a result may become hostile or non-compliant. This behaviour can result in frustration for the nurse, "taxing [their] patience as caring services still have to be provided" (Sumner 2008a, p.203). Nevertheless, the nurse must treat these difficult patients in the same professional way (Sumner, 2008a; NMC, 2018a; Smajdor, 2013).

Nussbaum (2001) suggests that our emotions and thoughts help us to understand ourselves and others. Personal histories and social norms shape emotions, forming judgements and informing decisions and actions (Nussbaum 2001). Based on the ILR, compassion is an emotion and, in this research, a theoretical understanding was adopted that compassion in nursing is understood to involve thought, judgment, and evaluation. Evaluative judgements guide the nurse's approach to communication, or the response needed to provide appropriate treatment. Sumner (2006) suggests fairness, equity, justice, and beneficence characterise bi-directional communication and, professionally, nurses are required not to judge the patient (NMC, 2018a). As Newham (2017) suggests, in nursing an expression of compassion may be morally

inappropriate but professionally necessary. An interpretation of compassionate care was developed from the ILR (p.70) and, in this elucidation, emotion and reason are recognised as intertwined. In participant feedback there is also recognition of the emotional impact of giving compassionate care, and the nurses' reasoning and evaluation within this.

Participants in the F1 TA referred to their professional responsibility of "duty of care" to protect patients and act as advocate (F1=10 (5S; 5Q)). The Code (NMC, 2018a, p.7) states that nurses should "act as advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour." F1 participants articulated disagreement that sharing the same background or culture with the patient made compassionate care easier (19: -3). In an example of RS feedback, participant S13 stated, "care/compassion should not be based on patient background/race/religion". Sumner (2007) emphasised that communication between nurse and patient, framed by the environment and the health/illness problem is regardless of race, culture, and gender (Sumner, 2012).

In contrast, F2 participants articulated agreement that sharing the same background or culture with the patient made compassionate care easier (19: +3). Further insight into the rationale for their agreement was provided in the TA results "connecting with the patient through similar background or understanding their culture means I can respond to their individual needs" (Q13). Consequently, participants in F2 did not view their responses as negative, seeing them instead as enabling them to respond to the unique needs of each patient. The contrast of views across F1 and F2 may have been influenced by the predominance of student nurses in F2 (n=4), with only one qualified nurse. The student nurses may be in the process of integrating their life experiences and prior social learning with their evolving professional identity and values. They may

not yet have sufficient experience to be able to understand non-similar backgrounds or cultures.

Sumner (2007) identified that nurse and patient bring their historical and cultural backgrounds to a specific health/illness situation as equals with assumed roles (Sumner, 2007). Participants across both factors recognised that relational aspects can be impacted upon by the cultural background of the nurse and patient and this is supported by research (Papadopoulos *et al.,* 2016a, 2016b; Babaei and Taleghani, 2019).

5.2.5 Summary of the impact of personal/relational issues on the provision of compassionate care

There was consensus across F1 and F2 that bi-directional communication and collaborative relationship building promoted compassionate care, and this is fundamental to Sumner's MCCNCAT (Sumner, 2008a). This collaboration must include the nurse, the patient their relatives/carers, and professional colleagues. Participants in F2 shared the view that part of the nurse's repertoire of understanding and engaging with the patient and colleagues can include using humour appropriately. This can enhance the patient experience and contribute to positive collegial relationships.

The views of participants on how they engage in compassionate relationship building revealed the moral dimension of the interaction. Compassion is recognised as an individual choice and a moral virtue (Pellegrino and Thomasma, 1993; Pellegrino 1995; Tuckett, 1999; Sinclair *et al.,* 2016c). Pellegrino understood the professional act of establishing trust, as essential to the relationship with the patient (Pellegrino, 1995). Tschudin (2003) added that both nurse and patient must have confidence in

and trust each other, and nurses build and reflect this trust in their behaviours and actions.

Participants felt strongly that sharing their own personal issues with patients would add to the latter's existing concerns and impact negatively on compassionate care. Participants were aware that certain values and beliefs could lead to prejudice or judgement and result in unacceptable behaviour and actions towards the patient. The influence of sharing the same background or culture with the patient was perceived differently by those in F1 and F2. Nevertheless, both factors emphasised that background or culture does not impact negatively on the provision of compassionate care. Also, a professional responsibility to the patient was recognised and this was regardless of external influences or the actions of others.

Participants in this research acted to enhance "the health-related existence" of the patient (Tschudin, 2003, p.8), "in accord with moral principles, rules and ideals" (Beauchamp and Childress, 2001, p.261). Tschudin (1998) identified that, at times of crisis, people turn to another for help and amongst the qualities and virtues required of another are that they are compassionate and just. A crisis can then be turned into a potential for human growth as a relationship develops and, because of this relationship, compassion becomes justice (Tschudin, 1998). Participants viewed the patient as the priority and the participants' own personal and professional values positively influenced the provision of compassionate care.

Building a compassionate relationship with the patient exposes the nurse's inherent vulnerability, as recognised and explained in the MCCNCAT. Nevertheless, participants across both factors identified their personal commitment, passion, and motivation to care. This was instrumental in their decision making when entering nursing and it supported them in their practice. Both factors linked the demonstration

of compassionate care to positive impact on patient outcomes, and their own satisfaction in care giving. The results of my research connected the satisfaction and motivation nurses derive from compassionate care-giving to personal wellbeing, professional commitment, job performance, positive collegial relationships, and positive patient outcomes.

5.3 Educational issues

5.3.1 Learning and developing compassion

Participants in both the F1 and F2 FAs were oriented to the view that compassion cannot be taught (34: F1 +3; F2 +5). Participants in the RS feedback viewed it as something that "you have" (F1=4 (2S; 2Q)); it is "innate" (F2=2 (1S; 1Q)); it "comes from within" (F1=7 (2S; 5Q), F2=4 (3S;1Q)); "from my upbringing" (F1=3 (1S;2Q), F2=3 (2S;1Q)). This was endorsed by the TA results. Although participants stated that compassion cannot be taught, in the TA results they said their understanding was enhanced by their clinical experiences of providing compassionate care (F1=13 (7S; 6Q), F2=5 (4S; 1Q)). Participants identified the need to engage in "real life situations that really affect people, it's not just a classroom, it's not theoretical" (Q4); the situation has to be "real" (F1=8 (5S; 3Q), F2=3 (2S; 1Q)).

Based on the TA results, participants (F1=10 (4S; 6Q), F2=5 (4S; 1Q)) attached value and benefit to their own maturity. They viewed their life experiences as positively influencing compassionate care. As participant S2 explained: "maturity has helped me become more self-aware." F2 participants also strongly agreed that their own life experiences of distress supported them in delivering compassionate care (25: +4). Sumner (2008a, p.131) said that

> maturity supports confidence in both the personal and professional self… Maturity, as experience, provides the nurse with the basis for reflection, [enabling] the ability to see oneself and the patient as human being rather than each functioning in one-dimensional 'roles'.

The shared view in F1 and F2 FA results was that professional development is important in improving standards of care (2: F1 +4, F2 +3). The TA results associated this with supporting safe, effective, and evidence-based practice (F1=6 (2S; 4Q), F2=3 (2S; 1Q)). Participants in the TA (F1=8 (4S; 4Q), F2=3 (2S; 1Q)) acknowledged that a professional requirement for nurses is to update knowledge and skills, to engage in "regular learning and professional development activities" (NMC, 2018a, p.20), in order to maintain competence. Participants recognised professional development as a professional requirement, contributing to maintaining standards. Within the MCCNCAT (Sumner 2008a) the *professional self* of the nurse includes theoretical, practical, and experiential knowledge, overlaid with the values of the nursing profession, with elements of duty and obligation. This nursing knowledge falls within the normative claim to truth. Participants viewed the updating of knowledge and skills as transferable and this could be structured and taught, whereas compassion, and the provision of compassionate care, were viewed as developing from experience, influenced by components of the *personal self* (Sumner 2008a). The nurse's *personal self* falls within the normative claim to truthfulness and the normative claim of rightness. It includes the nurse's personality traits, physical characteristics, different social roles, sense of identity, feelings, and inherent obligation to self (Sumner 2008a). Consequently, when applying the MCCNCAT to the research findings, the *personal selves* and the *professional selves* of nurses were viewed as impacting on their

experiences and learning. From this comes experiential knowledge gained from practice, positively enhancing the provision of compassionate care.

5.3.2 Classroom teaching does not link to the reality of practice

Attempting to teach compassion in a classroom setting, using didactic teaching methods, was viewed as inappropriate by participants in the F2 TA results. In order to develop compassion, there was a need to connect with the reality of practice, captured in the statement from participant S11, “in the classroom it’s… this is how it should be… but when you are out in practice its nothing like it”. This view is supported by Horsburgh and Ross (2013) as they suggest nurse academics can present an idealised view of practice that does not reflect reality. Also, an emphasis on knowledge-based competencies can result in a theory-practice gap (Bray *et al.,* 2014; Sinclair *et al.,* 2016b; Sinclair *et al.,* 2016c). The participants in F2 included 4 student nurses and one qualified nurse, with 3 years’ experience. The reality shock of clinical practice, when student nurses and newly qualified nurses experience dissonance between professional ideals they have been taught, the environment, and practice reality, is well recognised in the literature (Curtis, Horton and Smith, 2012; Curtis 2013; Horsburgh and Ross 2013; Bramley and Matiti, 2014; Richardson, Percy and Hughes, 2015). This dissonance can induce feelings of vulnerability, as they attempt to uphold professional ideals and challenge constraints with the realisation that they might need to adapt and conform to constraints (Curtis, Horton and Smith, 2012; Curtis 2013; Horsburgh and Ross 2013; Bramley and Matiti, 2014).

F1 and F2 FA results revealed differing views regarding the impact of knowledge on compassionate care. Participants in F1 viewed knowledge as impacting positively (33: +3), whereas participants in F2 viewed this with relatively low regard (33: -2).

However, in the TA results, participants across both factors viewed both life and clinical experiences as influencing their understanding of compassionate care. F1 participants associated this with support given by managers and leaders, demonstrating compassionate care through role modelling and demonstrating compassion to others. This support given in clinical practice created a positive learning environment. Participants in F2 viewed clinical experiences, including supporting patients in difficult situations (F2 = 4 (3S; 1Q)) as contributing to compassionate relationship building. They also associated their understanding of compassion with learning from life experiences and resulting maturity.

Participants in the F2 FA shared the view that their educational experience had not prepared them for the long term demands of practice (50: +3) and this finding is mirrored in other research studies (Horsburgh and Ross, 2013; Papadopoulos *et al.,* 2016b; Sinclair *et al.,* 2016b; Babaei and Taleghani, 2019). In the NMC standards for education and training, set out in three parts (NMC; 2018c, 2018d, 2018e), there is no reference to compassion or compassionate care. Each document identifies that nurses "must practise in line with the requirements of The Code" (NMC; 2018c, 2018d, 2018e), in which the requirement for compassionate practice is explicit. Existing evidence confirms that compassion is not always apparent in the nursing curriculum (van der Cingel, 2014; Papadopoulos *et al.,* 2016a, 2016b; Sinclair *et al.,* 2016b; NMC, 2018c). Also, nurse academics have restricted time and opportunities to prepare for and evaluate their role in nurturing compassionate and caring attributes in student nurses (Smith *et al.,* (2014). Also impacting on the process are restrictive elements such as large student groups, and nurse academics focused on university goals related to research output, recruitment, retention, and student satisfaction (Curtis, 2013). Curtis (2013) suggests the experience of nurse academics could be enhanced

through further opportunities for reflection, continuous individual feedback, and additional sources of support. It is important that the educational standards for nursing guide curriculum development and implementation in order to support the development of the skills, knowledge and attitudes required to deliver care with compassion (Horsburgh and Ross, 2013; Bramley and Matiti, 2014).

5.3.3 Limited learning opportunities in practice

Participants in F2 FA strongly disagreed that opportunities to discuss issues in practice are regularly available (47: -4). The negative impact of an ever-increasing workload, reduced staffing levels and inadequate resources translates into significant educational barriers in the development of compassionate care (Blomberg *et al.,* 2016; Sinclair *et al.,* 2016c). These barriers also include time constraints that limit mentoring, group, and self-reflective opportunities (Curtis 2013; Bray *et al.,* 2014; Sinclair *et al.,* 2016b), poor quality of mentoring (Bray *et al.,* 2014; Sinclair *et al.,* 2016b), and reduced staffing and resources (Christiansen *et al.* 2015; Papadopoulos *et al.,* 2016a, 2016b; Sinclair *et al.,* 2016b). The tensions nurses experience between work-based pressures and attempting to maintain professional ideals impact on their learning (Curtis, Horton, and Smith, 2012).

The results of my research have identified the benefit of supportive, collaborative and reciprocal relationships with colleagues. Theodosius (2008) suggested such relationships, can help nurses manage emotional labour and can be developed through role-play in peer coaching sessions (Kinman and Leggetter, 2016). To realise these benefits, opportunities to build relationships with colleagues must be supported by the organisation and reflected through the behaviour and actions of managers, leaders and mentors in their daily practice.

5.3.4 Creative approaches to develop compassionate care

Participants in TA across both factors recognised the value of practice experience and connecting experiences to the development of compassion. From an educational perspective, Willis (2012), Francis (2010), and HEE (2015) emphasised the importance of developing compassionate nurses. Therefore, the educational process, involving practice and university, must enable nurses to develop the attributes and emotional capacity required to deliver care with compassion (Willis report, 2012; Francis 2010, 2013; Adam and Taylor, 2014). Research suggests that nurses learn from personal, university and practice experience, influenced by nurse academics, practice-based nurse mentors, and by the environment in which nursing takes place (Curtis, Horton and Smith, 2012; Curtis, 2013; Dewar and Nolan, 2013; Bray *et al.,* 2014; Christiansen *et al.,* 2015; Jones *et al.,* 2016; Sinclair *et al.,* 2016a). However, the cultivation of compassion may be contingent on the innate human qualities that learners possess at baseline (Bramley and Matiti, 2014; Kneafsey *et al.,* 2015; Papadopoulos *et al.,* 2016a, 2016b; Sinclair *et al.,* 2016b, 2016d, 2018). For some it may be a natural disposition or intuitive (van der Cingel, 2011), while for others it may slowly emerge through experience (Sinclair *et al.,* 2016a) and can be learned (van der Cingel, 2014).

Sumner (2008a, p.124) said "the nurse must have a broad and deep knowledge of all the components for the human condition for optimum practice". This reference to the human condition is not limited to the illness role but includes the art of nursing, the knowing how, the use of aesthetic knowledge (Carper, 1978). Carper developed the Fundamental Patterns of Knowing in Nursing, integrating empirics. aesthetics, ethics and personal knowing. The process of 'knowing' requires scientific knowledge and skills that constitute the empirical knowing. The theoretical underpinning of nursing

care is vital in nursing, but so is aesthetic knowledge, in order to frame judgement, enhance communication and apply theoretical knowledge competently, thoughtfully, and creatively (Sumner, 2008a). Aesthetic knowledge requires reflection, enabling the nurse to use past experiences to shape present care and to meet the patient's needs. The personal knowing involves the therapeutic use of self in which nurses interrelate openly with the patient, expressing their authentic selves. Finally, ethical knowing is reflected in their efforts to provide individualised holistic care. To raise understanding and awareness of the interrelatedness of 'knowing' in nursing requires approaches to learning that span both education and practice. They must embrace differing learning styles and learning environments, valuing the experience of nurses.

Creativity is required in nursing education, spanning university and clinical practice in order to capture the empirics, aesthetics, ethics and personal knowing in nursing, and to support the development of compassionate care. Nussbaum (2003) suggested that, to develop compassion, we must give the humanities and the arts a large place in education. Terry *et al.,* (2017, p.10) added "the arts in all their forms, not just books, poems, articles, plays and films, can engender reflection, response and change".

Research studies have explored approaches to developing compassion, as exemplified in the work of Costello and Barron (2017). They integrated Watson's Caritas Processes (Watson, 2008) into course modules addressing issues in end-of-life situations, the aim being to foster interpersonal, and intrapersonal, relationships and explore caring in nursing. Approaches to learning included the use of videos, lectures, discussion, and reflective journaling, designed to introduce students to the foundation of Caring Science (Watson, 2008). Each class began with meditation and ended with an expression of gratitude. Students were required to develop a creative artistic expression related to caring at the end of life. These approaches allowed

students time to practice self-care strategies and to reflect on, and learn from, their experiences. On completion of modules, students reported increased self-awareness in the provision of compassionate care at the end of life (Costello and Barron, 2017).

Richardson, Percy and Hughes (2015) conducted a literature review on caring, compassion, and empathy and from this designed and implemented an undergraduate unit of study. Applying Muetzel's (1988) model for understanding therapeutic relationships, students explored how they would exhibit caring, compassion, and empathy whilst undertaking nursing interventions. Justification for the choice of this model, rather than another, was not given. The results suggest materials could be developed to enable students to learn how to care using compassion. However, there is no evidence that this learning is then evident in their practice. Research studies associated with the LCCP (Adamson and Dewar, 2015) focused on approaches to enhancing compassionate care. Adamson and Dewar (2015) used stories gathered within clinical practice to stimulate reflective learning as part of a nursing module. It was suggested that this approach can develop knowledge, skills and confidence in student nurses, enabling provision of relationship centred care. However, results were not linked to impact on student behaviour in practice. Dewar and Nolan (2013) developed a conceptual model based on appreciative, caring conversations. Their study involved healthcare staff and relatives. Data were generated using storytelling, observation, group discussion, and photo elicitation. It was acknowledged that the model required further development but nevertheless the research revealed the importance of a supportive environment in which leadership values and facilitates compassionate care. Dewar and Mackay (2010) developed positive caring practice statements, from which action plans were developed to enhance compassionate care

in an older person setting. Processes found to be pivotal to conveying compassion included support, valuing relationships, and engaging in reflection.

The approaches to teaching and learning explored, recognised, valued, and built on the existing experiences of nurses. It has been asserted that experiential and creative methods can contribute to the development of the skills and understanding required for compassionate care. Participants in my research emphasised the important of valuing their existing experience and connecting learning to clinically based experiences. For this to be achieved collaboration must be strengthened between education and nursing praxis in order to facilitate the realignment of practice reality with professional ideals.

5.3.5 Values based recruitment practices can contribute to compassionate care

Participants in the F1 FA shared the view that "recruitment of already compassionate individuals ensures compassionate care" (48: F1 +3). From the TA results, participants identified that exploring existing skills and knowledge related to compassion (F1=8 (4S; 4Q)) and valuing the life experiences of applicants (F1=2 (2Q)) could support recruitment practices. It has been shown that participants were motivated by the desire to care when applying to become nurses and Sumner (2008a, p.239) suggested that the wish to help others is a motivating force and provides inner resiliency. The importance of recruiting students with the appropriate values to pre-registration nursing courses and roles within the NHS has been captured in policies, reports, and research (DH, 2012a; Mclean, 2012; Francis, 2013; Fry *et al.,* 2013; Waugh *et al.,* 2014; Newdick and Danbury, 2015; NHS Employers, 2018). Also, Health Education England (HEE, 2014, 2016) implemented the National Values Based Recruitment programme with the aim of recruiting nurses who have appropriate values

and motivation for the NHS. However, as identified by Richardson, Percy and Hughes (2015), even if students are recruited with the right values these can change throughout the nursing course as they become exposed to the reality of practice.

Recruitment and selection strategies need to assess the values of applicants. Their experiences should be incorporated into this assessment. Durkin, Gurbutt and Carson (2018) recommended that a compassion scale could be used to assess ability prior to commencing a nursing course. The combination of an assessment of values and understanding of compassionate care, linked to the experiences of the individual, could form a baseline assessment to inform future support and action planning. Ongoing support should involve both the university and practice.

5.3.6 Summary of the impact of educational Issues on the provision of compassionate care

Both factors recognised the value of learning. This is evident in their view that professional development improves standards of practice. However, in contrast they did not view compassion as something that can be taught using didactic classroom-based approaches.

Participants in both factors viewed compassion as developing in early life and influenced by experiences and maturity. As Sumner (2008a) suggests, experiential knowledge involves reflection. The nurse learns from experience, accordingly adapting knowledge to the new situation, which leads to 'fluidity of movement, adroitness, coordination, and efficiency" (Johnson 1994, p.8). From the findings in this research, it is suggested that fostering experiential approaches to learning could connect with the experiences of nurses and encourage understanding of the patient's world. To provide a curriculum than spans education and practice, nurse academics and clinical staff must have the time and opportunity to reflect, prepare, and evaluate

their roles in nurturing compassionate and caring attributes of both students and qualified nurses. Nurses in the practice environment must also witness and experience compassion – as when compassion is valued and experienced, nurses are better able to show compassion to others (Papadopoulos *et al.,* 2016a).

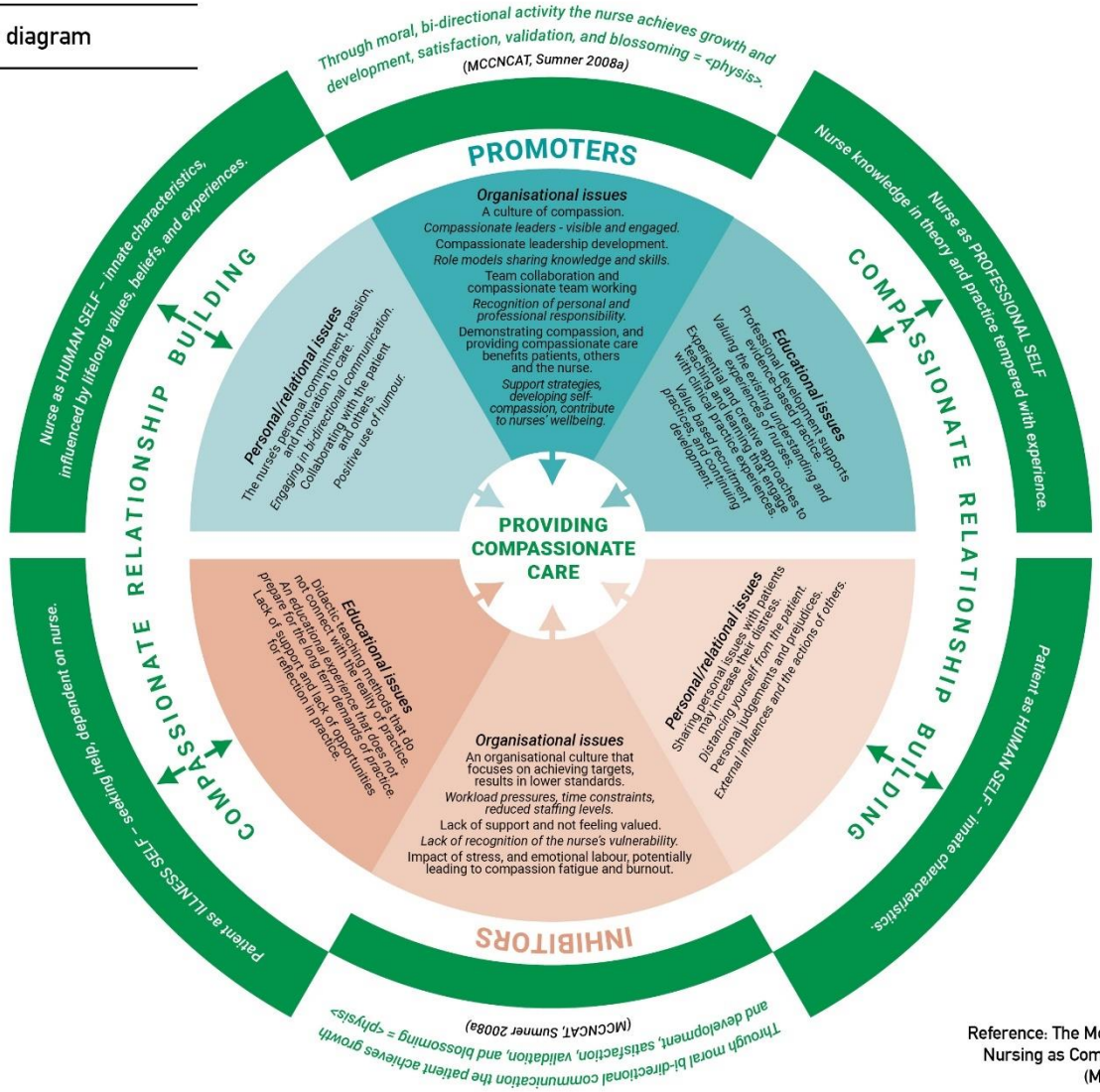
It is suggested that evaluating the compassion aptitude of applicants prior to, or in the early stages of, their nursing course contributes to the realisation of compassion in practice, encouraging and enhancing existing strengths over time, and linking practice and educational experiences through dialogue, reflection and action planning.

5.4 Research outcomes and explanatory diagram

The research findings revealed how nurses negotiate the complexities of providing compassionate care. An explanatory diagram has been created (Figure 5), influenced by the MCCNCAT (Sumner 2008a) and reflecting issues that were found to impact on the provision and maintenance of compassionate care.

Figure 5 places 'providing compassionate care' at the centre. Surrounding this are the three overarching themes that impact on compassionate care, *Personal/relational issues, Organisational issues*, and *Educational issues*. For clarity, the promoters and inhibitors are presented separately within these overarching themes. Compassionate relationship building appears in the next circle. The components of the MCCNCAT (Sumner 2008a) illuminate the interrelatedness, interdependence, and influence of the

Figure 5	Explanatory diagram



Reference: The Moral Construct of Caring in Nursing as Communicative Action Theory (MCCNCAT) (Sumner 2008a)

personal self and the *professional self* of the nurse, and the *personal self* and *illness self* of the patient, when building compassionate relationships. To achieve compassionate care both the nurse and patient invest in compassionate relationship building. The nurse is willing to give of themself, building trust with the patient, and the result is "commitment and mutuality, or caring in nursing as moral communicative action" (Sumner, 2008a, p.21).

The patient seeks help or assistance from the nurse, and the nurse provides this based on their knowledge and inherent human vulnerability. The moral bi-directional activity between nurse and patient is fundamental to compassionate relationship building.

Nevertheless, Sumner (2008a, p.41) argues that the patient may appear more vulnerable than the nurse. However, the "intimacy which exists in the nurse/patient relationship" results in the vulnerability of both, and in the need for considerateness. When bi-directional communication and relationship building is characterised by care and compassion, the interaction becomes moral and is mutually rewarding, leading to 'physis' – validation and blossoming (Sumner 2008a).

Organisational Issues – *(discussed in section 5.1.3)*

Promoters

An organisational culture that supports and values compassionate care, and leaders and managers who are visible and demonstrate compassion promote compassionate care giving. Compassionate leadership development would contribute to understanding, support, and role modelling of compassionate care. At all levels, when staff act as positive role models in practice, sharing their knowledge and skills, and teams work collaboratively and demonstrate compassion to each other, compassion is enhanced. Nevertheless, participants said they have a personal and professional

responsibility to provide compassionate care, regardless of the skills of others or external influences. The satisfaction gained from providing compassionate care creates a virtuous circle, increasing personal motivation enhancing participants personal wellbeing, professional commitment, and job performance, and supporting collegial relationships and positive patient outcomes. Engaging in self-kindness and self-care strategies, including self-compassion, contributes to nurses' wellbeing.

Inhibitors

A target driven, conveyor belt approach to care, inhibits compassionate care provision and results in lowering of standards. The organisational culture and the actions of management must reflect the values and beliefs that support compassionate care. Considerateness and support are required from the organisation, managers, and leaders. There must be recognition that work-based pressures have a profoundly negative impact on the experiences of patients, on the wellbeing of nurses, and on nurses' ability to provide compassionate care. When the investment of nurses in the provision of compassionate care is not valued, this can result in increased stress, emotional labour, compassion fatigue, and eventually burnout. It is essential to have strategies for sustaining their wellbeing, including support mechanisms and recognition that compassionate care requires high levels of skill and support.

Personal/relationship Issues *(discussed in section 5.2.5)*

Promoters

Commitment, passion, and motivation to care were instrumental in participants' decisions to enter nursing and continued to support them when providing compassionate care. The compassionate relationship developed between the nurse and patient was underpinned by bi-directional communication, characterised by care

and compassion. Collaborating with the patient, building a compassionate relationship of confidence and trust, required a willingness to engage with and be affected by the patient's experiences. The positive use of humour was recognised as contributing to compassionate relationship building. This can enhance the patient experience and contribute to positive collegial relationships.

Inhibitors

Inhibitors that impact on compassionate care were identified as sharing personal issues with patients, as this may add to their concerns. When the nurses distance themselves from the patient, or allow external influences, personal judgements and prejudices to influence their behaviours and actions, this impacts negatively on compassionate relationship building.

Educational issues – *(discussed in section 5.3.6)*

Promoters

Nurses learn from personal, university, and practice experience. To maintain and improve standards and support evidence-based practice, professional development is required. However, the understanding of compassion and compassionate care and its provision is influenced and enhanced by life experiences, maturity, and practice-based experiences. Experiential and creative approaches to learning are needed that value existing experience and understanding. Recruitment practices can contribute to compassionate care through recognition of existing values and experiences.

Inhibitors

- Didactic teaching methods that do not connect with the reality of practice
- An educational experience that does not prepare for the long term demands of practice

- Lack of support, or of opportunities for reflection in practice.

Didactic classroom-based teaching was not appropriate in the cultivation of compassion. To prepare nurses for the long-term demands of practice, both university and practice must work together to create a curriculum that encompasses theory and engages the experiences of learners. Opportunities must be available for nurses to reflect on, and learn from, their experiences in practice, the aim being to connect theory to the reality of practice and align it to professional ideals.

In summary

The findings from my research are made visible in Figure 5, offering insight concerning the promoters and inhibitors to compassionate care and suggesting actions and strategies that will support its achievement.

In this research, the rigorous application of Q methodology meant that qualitative data relating to confounded (therefore excluded) Q sorts was omitted. However, a quotation from the RS feedback of participant Q1, a confounded Q sort, is worthy of discussion, "Medication heals the wounds but compassion treats the broken heart and sees the scars".

Watson (2008) says distilling the essence of compassion is challenging. Nevertheless, this quotation from participant Q1 suggests that, by providing care with compassion, the nurse demonstrates a willingness to recognise the apparent, and potentially hidden, needs of the patient and to respond to those needs. Through her or his humanity, the nurse is offering healing. This exemplifies a pattern of behaviour towards those in need.

Gilbert (2010) suggests our emotions are regulated by three systems, each designed to do different things, to be in balance with and counterbalance each other. The three systems will be used to interpret this quotation:

- The *threat and protection system* – By responding to the patient's needs the nurse acts against the immediate threat and the patient seeks the help of the nurse in response to their illness threat.
- The *incentive and resource seeking system* – The nurse is motivated to build a compassionate relationship with the patient, engaging in bi-directional communication, attempting to heal the patient's mind/soul to help them prosper. From the provision of care with compassion, the patient experiences satisfaction, validation and blossoming.
- The *soothing and contentment system* – By demonstrating compassion and providing compassionate care, the nurse allows the patient to feel safe as the authentic, but scarred, person they are.

The quotation from participant Q1, "Medication heals the wounds but compassion treats the broken heart and sees the scars", captures the precious nature of compassion. The quotation encapsulates Figure 5, reflecting the results of my research and its alignment to the MCCNCAT (Sumner 2008a). The quotation speaks to the heart of 'Providing compassionate care', presented at the centre of Figure 5. When the patient actively seeks help, they present with their personal self and illness self. The personal self of the patient includes their sense of identity, their personality traits, different social roles, their feelings and experiences. The quotation identities that, within their personal self, the patient also brings their broken heart and scars, evidence of their suffering. The patient actively seeks help from the nurse and in doing so their inherent vulnerability is revealed. The 'wound' is the patient as illness self and

accepting medication (treatment) is recognition by the patient that they are in need of the nurse's professional self. The nurse provides the 'healing' of compassion by recognising and attempting to alleviate the suffering of the patient, working with them to build a compassionate relationship. This is enabled through the nurse's personal self, from their maturity and experience, and their professional self through their theoretical, practical, and experiential knowledge. Both nurse and patient contribute to the compassionate relationship, which is mutually rewarding and leads to validation and blossoming (Sumner 2008a).

My research has explored in detail how compassion is expressed and shaped in nurses' daily actions, and identified strategies used to achieve compassionate care alongside competing demands and priorities. The provision of compassionate care requires nurses to respond with humanity and kindness to the needs of another, to provide comfort and relieve suffering. With increased understanding the enactment of compassionate care can be realised.

Chapter Six – Conclusion

The application of the MCCNCAT (Sumner 2008a) as the theoretical framework, and the use of Q methodology and additional qualitative date collection methods supported the aims of my research and revealed that compassionate care is complex, interconnected, and multifaceted. My research findings provide an in-depth understanding of the promoters and inhibitors to compassionate care from the viewpoints of nurses, de-mystifying how they maintain such care in their daily practice. I have used the findings to formulate an interpretation of compassionate care and construct an explanatory diagram. Collectively these results clarify the nature of the essential support and strategies needed to contribute to the achievement and maintenance of compassionate care.

This research will be of interest to nurses, other health care professionals, healthcare employers, managers, Higher Education Institutions and providers of in-service training.

6.1 Personal reflections

In our lives, we are faced with challenges that test our fortitude. The journey to completion of my doctoral studies has represented such a challenge. It has taken longer than planned and has had moments of pleasure and extreme pain in equal measure. Nevertheless, this programme of study has enabled me to grow personally, professionally and academically. The course modules encouraged me to examine and interrogate my knowledge and skills, and to consider aspects of my own beliefs, both ontological and epistemological, I had not previously considered. My understanding has grown, particularly in relation to interpretation and

operationalisation of the methodology and methods used in this research. New knowledge and skills have enriched my life and will continue to do so.

6.2 Contributions of my research to practice

My findings are credible, rigorous and trustworthy and my research processes robust. The factor analysis and additional qualitative data collection methods revealed the complexity and interconnectedness of compassionate care. My research findings indicate consensus from both student nurses and qualified nurses in three key areas:

- *Personal/relational issues* – Improved patient outcomes not only impact positively on the patient but also motivate participants to provide compassionate care. The personal commitment, passion, and motivation to care, are instrumental in participants' decision making about entering nursing and continue to support them in their practice. This commitment results in successful nurse-patient interactions, supporting nurses' professional responsibility of a duty of care to the patient, and achieving the best possible outcomes for patients. The satisfaction gained from providing compassionate care creates a virtuous circle, increasing personal motivation and enhancing participants' personal wellbeing, professional commitment, and job performance. It supports collegial relationships and positive patient outcomes.
- *Organisational issues* – The organisation must value compassionate care, supporting nurses and providing necessary resources. My research identifies that participants strive to provide compassionate care against a backdrop of limited resources, inadequate staffing levels, and workload pressures. They are left feeling vulnerable when confronted by external constraints in practice over which they do not have control. For nurses to practice compassionately they need to feel content, safe, and protected. Strategies to support and value

nurses in compassionate care provision include the development of a culture of compassion, whereby demonstrations of compassion are made visible by managers, leaders, and colleagues to both patients and others. In addition, to contribute to their own wellbeing nurses must engage in self-kindness and self-care strategies, including self-compassion.

- *Educational issues* – Didactic, classroom-based approaches are inappropriate for cultivating compassion and compassionate care. Teaching and learning must connect the nursing curriculum to the clinical experiences of nurses. Recommendations include utilising experiential and creative approaches and strengthening collaboration between education and practice. Further investment is necessary to bring education and practice together, enabling the application of learning to the reality of practice.

6.3 Strengths and limitations of my research

Q methodology has not previously been used in the exploration or study of compassionate care. It has provided the methodological framework in which to study the subjective viewpoints of nurses through co-production that is contextualised to the clinical environment in which they work. The strength Q methodology has to combine both qualitative and quantitative research, and the use of additional qualitative data collection techniques, has resulted in both an affirmation and an extension of existing knowledge.

Applying Sumner's (2008a) established formal theory of caring in nursing (MCCNCAT) as the theoretical framework has enabled a coherent explanation of phenomena and relationships in compassionate care giving. It has enriched understanding of the complexities of providing compassionate care in an ever changing and challenging environment.

To some extent the power of these findings is limited by the need to reduce the original sample size to exclude several participants who shared common views across both factors, meaning that their Q sort was confounded. A larger sample size might have overcome this limitation. The research participants worked or experienced placements within one Trust hospital setting. Consequently, their views may not reflect those of all nurses. The aim, however, was not to produce findings that were wholly generalisable but to capture currently expressed viewpoints. The detailed descriptions in this research should enable those seeking generalisability to determine whether my findings are applicable to their situations. The research involved student nurses undertaking a BNurs Adult Nursing course and qualified nurses registered in the adult speciality. It is conceivable that data from nurses from other specialities, such as child, learning disability, or mental health nursing, could have enhanced this study, as they might have different experiences of compassionate care within their settings.

6.4 Suggestions for future research and policy development

The research reveals that many participants believe compassion to be innate, developed early in life; it cannot be taught but could be cultivated. Consequently, recruitment to nursing may benefit from further research into the baseline attributes, beliefs and values of applicants, and their comparison with beliefs and values at qualification and beyond.

Within my research, humour has been identified as a strategy that contributes to compassionate relationship building and team support. Further research is needed to establish how the appropriate use of humour can support the development of compassionate relationships, individual resilience, and collaborative team working.

Participants found the process of Q sorting to be positive in revealing and challenging their viewpoints on compassionate care. I believe a future research project involving senior managers, clinically based nurses, and patients, would be valuable in exploring viewpoints on compassionate care and how it is enacted in practice. This would inform both government and organisational policy development.

To maintain compassionate care, government policy must guide and reinforce the benefits to nurses of developing compassionate cultures. Integral to this is the development of compassionate leadership, requiring investment from government and organisations.

My research findings have informed the construction of an explanatory diagram reflecting issues that were found to impact on the provision and maintenance of compassionate care. Sumner's MCCNCAT (Sumner, 2008a) supported its development and contributed to the structure. The explanatory diagram offers a foundation on which to construct further research to confirm and extend the research findings and test theory.

6.5 In conclusion

Compassionate care is valued by nurses and seen as integral to their practice. This research has made the complexity and interconnected nature of compassionate care visible. The dynamics involved in compassionate relationship building, the promoters and inhibitors to its achievement, and the realisation of compassionate care have been elucidated. The explanatory diagram offers the foundation for further research that will potentially confirm and extend the research findings.

As Sumner (2006, p.14) suggests, “all knowledge is interpretive and builds on the shoulders of that which has gone before.” This research contributes to existing understanding of the provision and maintenance of compassionate care. I hope that the results will ‘reach out’ to nurses, encouraging them to debate and influence the provision of compassionate care in present and future nursing practice. The future will bring challenges but also tremendous opportunities.

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Appendix 1 – Summary of the quality appraisal of the qualitative studies (Kmet, Lee and Cook, 2004)

	1	2	3	4	5	6	7	8	9	10	
Author	Question /objective sufficiently described?	Study design evident and appropriate?	Context for the study clear?	Connection to theoretical framework/ wider body of knowledge?	Sampling strategy described, relevant and justified?	Data collection methods clearly described and systematic?	Data analysis clearly described and systematic?	Use of verification procedure(s) to establish credibility?	Conclusions supported by the results?	Reflexivity of the account?	Total score out of maximum of 20
Scoring	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 No = 0	Yes = 2 Partial = 1 No = 0	Yes = 2 Partial = 1 No = 0	
Adamson and Dewar (2015)*	2	1	2	2	2	2	1	0	1	0	13/20
Babaei and Taleghani (2019)	2	2	1	0	2	2	2	2	2	0	15/20
Badger and Royse (2012)	2	1	2	0	2	2	2	2	2	0	15/20
Bramley and Matiti (2014)	2	2	2	0	2	2	2	1	2	1	16/20
Curtis, Horton and Smith (2012)	2	2	2	1	2	2	2	1	2	0	16/20
Curtis (2013)	2	2	2	1	1	1	1	2	2	0	14/20
Dewar and Mackay (2010)*	2	2	2	2	1	2	1	2	1	1	16/20
Dewar et al. (2010)*	2	2	2	2	1	2	1	2	2	0	16/20
Dewar and Nolan (2013)*	2	2	2	2	1	1	1	2	2	0	15/20
Fry et al. (2013)	2	1	2	0	2	2	2	0	2	0	13/20

Graber and Mitcham (2004)	2	2	2	0	1	2	1	2	2	1	15/20
Horsburgh and Ross (2013)*	2	2	2	2	1	2	2	2	1	0	16/20
Jones et al. (2016)	2	2	1	0	1	1	1	2	1	1	10/20
Kneafsey et al. (2015)	2	2	2	0	2	2	2	2	2	0	16/20
Kvangarsnes et al (2013)	2	2	2	1	1	1	2	1	2	2	16/20
MacArthur et al. (2017)*	2	2	2	1	2	2	2	1	2	0	16/20
Perry (2009)	2	1	1	0	1	1	1	2	2	1	12/20
Sinclair et al (2016a)	2	2	2	2	1	2	1	2	2	0	16/20
Sinclair et al (2016c)	2	2	2	2	1	2	2	1	2	0	16/20
Sinclair et al (2016d)	2	2	2	2	2	1	1	2	2	0	16/20
Sinclair et al. (2018)	2	2	2	2	1	1	2	2	2	0	16/20
Singh et al. (2018)	2	2	2	0	2	2	2	2	2	0	16/20
Smith et al. (2014)*	2	2	2	2	1	1	2	0	2	0	14/20
Sumner (2008b)	2	2	2	2	1	1	1	0	2	1	14/20
Van der Cingel (2011)	2	2	2	2	2	1	1	2	1	1	16/20
Way & Tracy (2012)	2	2	2	0	1	1	1	2	2	1	14/20
26 studies											

Appendix 2 – Summary table – papers included in the literature review

*Research studies that drew on data from the LCCP

Author(s) year and country of origin.	Design	Sampling strategy	Response rate and participant numbers	Outcomes	Critique	Scoring system and score
Edinburgh Napier University and NHS Lothian (2012) 3-year action research project (2008-11). Final Report: Adamson et al. 2011 UK	Design followed three key theoretical principles: Action Research, Relationship Centred Care, and Appreciative Inquiry. Four strands were created: the establishment of Beacon Wards – centres of excellence within a hospital; facilitating the development of leadership skills; to embed relationship-centred compassionate practice into the undergraduate curriculum; and supporting newly qualified nurses.	Purposeful and theoretical sampling used. Involved 8 participating wards. Collaboration between university and practice.	Recruitment reported against each research 'strand.' Patients, relatives, NHS staff, lecturers, student nurses. 33 clinical settings and 106 individuals.	Factors that helped achieve compassionate care was the creation of dedicated spaces to have 'caring conversations' to discuss practice; linking, aligning and integrating compassionate care activities to other organisational processes, targets and quality incentives; having support from senior management; development of reflective forums; creation of a leadership programme; and involvement of service users and carers in shaping the service and curriculum delivery.	Funded by benefactor. Level of adoption varied across wards. Low level of adoption of programme in certain practice areas resulted in limited outcomes. The results published in the final report included recommendations from subsidiary research studies that drew on data from the LCCP. NB: The results were published in a 198-page final report (Adamson *et al.,* 2011), and additional research papers were published, seven of which have been included in this review. These include the research papers of Adamson and Dewar (2015)*, Dewar and Mackay (2010)*, Dewar et al. (2010)*, Dewar and Nolan (2013)*, Dewar and Cook (2014)*, Smith et al. (2014)*, and Horsburgh and Ross (2013)*.	N/A
Adamson and Dewar (2015)* UK	Part of LCCP. Appreciative Inquiry. Stories gathered in practice were used to stimulate	Individual consent gained from students to use discussion	Student nurses (n=37) enrolled onto module. 37 listened to podcasts and 33 viewed stories.	Use of stories about the experience of giving and receiving care can develop knowledge, skills and confidence in student nurses enabling provision of relationship centred care.	Participant sample size studying adult nursing course was relatively small and limited number of students participating in online discussion may not be representative of student nurses in general. Confusing use of term nursing	Kmet, Lee and Cook 13/20

	reflective learning as part of a nursing module using blended learning approach.	content from interactions in online discussion forum.	Only 16 students added posts to online discussion.	Student stories stimulated reflection on their own beliefs and values that can inform planning and delivery of person-centred compassionate care.	student when registered nurses were also involved as participants. Results not linked to impact on student behaviour in practice.	
Babaei and Taleghani (2019) Iran	Ethnographic study. Data analysis based on constant comparative method. Data gathered from observations and semi-structured interviews.	Purposive sampling. Recruited from 10 medical and surgical wards of two teaching hospitals.	40 Nurses (n=40). Female (n=32) and male (n=8) of differing ranks (not stated). Patients (n=16) and family members (n=8). Total (n=64). Demographic data recorded.	Inconsistency between workload, insufficient time and staff resulted in nurses lack of motivation and exhaustion; focus on routines instead of patients. Identified lack of role models for compassionate behaviour; and education not preparing them to provide compassionate care. Gender difference between the nurse and patient also created problems in communication and provision of physical care; and difficulty in interpretation of the patients spoken language.	Main researcher and two academic staff were involved in data collection. Main researcher was observer and contributed to some nursing activities which may have influenced results. Time integration method was used – sampling three times at morning, noon and night which contributed to validity. Data credibility was ensured through member check. Ethical consideration not discussed in detail.	Kmet, Lee and Cook 15/20
Badger and Royse (2012) USA	Qualitative. Explored burn survivors' descriptions of compassionate healthcare to explicate and better understand the concept within the context of burn care.	Purposive sampling.	31 burn survivors, 52% of total (n=16) trained peer supporters. 2 focus groups. Total n=31 burn survivors. Focus group participants completed demographic questionnaire and were invited to respond to open-ended questions.	3 themes emerged: respect the person; communication; and provision of competent care. Themes viewed as interconnected and holistic, conceptualising compassionate care from perspective of survivors.	Focus groups were conducted at a burn survivors conference, consequently, may not be representative of all burn survivors. Participants self-selected to attend conference, engage in focus groups creating potential for bias. Context of setting, group dynamics may have influenced feedback. Participants included trained peer supporters but these were limited to one focus group so data could be compared for similarities and differences.	Kmet, Lee and Cook 15/20
Bramley and Matiti (2014) UK	Qualitative exploratory descriptive study exploring patients' experiences of compassion in care.	Purposive sampling. Nursing staff identified participants who matched inclusion	Patients from 6 medical wards (total n=10). Female (n=5), 5 males (n=5). Inclusion criteria: adult inpatient longer than 24	3 themes emerged: *what is compassion*, a unique experience personalised to individuals in relation to their own needs, developing a relationship and giving time to care, importance of small gestures; *understanding the impact of compassion*, patients wanted nurses to understand 'how it feels to be in their shoes'; and	Small sample size, exclusion of sick patients and those with dementia, and lack of cultural diversity limits transferability. Nursing staff on wards selected patients, this may have resulted in biased feedback from patients. Debriefing of patients following interview not discussed.	Kmet, Lee and Cook 16/20

	Semi-structured interviews.	criteria, then approached to identify willingness to participate.	hours and within 24 hours of discharge. Able to consent. Not cared for by primary researcher.	*being more compassionate*, patient opinion was divided whether compassion can be taught or is a moral virtue. Patients identified the impact of hospital and ward cultures on the behaviour of staff.	Use of reflexivity discussed.	
Bray et al. (2014) UK	Sequential explanatory mixed methods. Survey gathered self-reported data on the meaning of compassion; perceptions of barriers and facilitators; and whether compassion can be taught. Interviews explored subjective experiences to illuminate quantitative data.	Stratified purposive sampling. Conducted in a single university where all participants were undertaking academic and/or professional qualifications	Questionnaire completed by healthcare students (HCS) (n=197) and healthcare professionals (HCPs) (n=155). Total (n=352). Interviews conducted HCS (n=7) and HCPs (n=7). Total (n=14). Exclusion criteria not identified.	Survey data revealed participants had consensus of understanding of what compassion is, and how it is communicated to patients (active listening, respecting patients' dignity and privacy, and being attentive to patients' needs). HCPs (34%) and HCS (46%) believed compassion cannot be learnt, taught or measured, although majority of participants were unsure. Clearer consensus from HCPs that training was necessary. 2 themes developed from interviews: compassion versus knowledge; and learning, developing, and teaching compassion. Knowledge, competence, and evidence-based practice seen as essential to safe and effective care. Workplace pressures impact on care provision.	Sampling and response rates clearly stated. Although a range of different disciplines and professionals were involved most data resulted from qualified nurses (n=123) or student nurses (n=125). Participants were actively involved in further education and therefore their views may not be representative of all nurses. Results of both quantitative and qualitative data was integrated. The barriers and facilitators to providing compassionate care could have been grouped more explicitly. The likelihood of being able to assess compassionate care in practice and educational settings could also be made more explicit. Issues around researcher bias were not considered.	MMAT 60%
Burnell, L. (2009) USA	Concept analysis using Walker and Avant's methodology.	N/A	N/A	Recommends research should be undertaken into nursing interventions for compassionate care. It is stated prior to this, nurses should be taught the concept of compassion according to the attributes of professional caring (Roach 2007). However, there is no discussion about the feasibility of teaching compassion.	Focus on religious views and practices. No discussion of how compassionate care can be provided by nurses with no specific religious faith. Refers frequently to results of Schantz's concept analysis. Question integrity of references; Wikipedia and 'God on the Net' are used.	
Burnell and Agan (2013) USA	Survey design. Developed Compassionate Care Assessment Tool (CCAT) from combined findings from two pilot	Purposive sampling. Inclusion criteria: adult, English	Patients (pilot study, n=110; final study, n=250) Surveys were administered to 250 patients in the USA with 177 of	Factor analysis identified four subscales (significantly correlated with each other p>0.001): *Meaningful connection* incorporated viewing the patient holistically the characteristics required of the nurse to establish a relationship was; humour,	Nonprobability sampling used therefore not offering equal chance of inclusion. The CCAT addresses several core variables that have been identified as acts of compassion, including virtues, communication, responding and helping. It does not assess understanding of	MMAT 80%

	studies using a Spiritual Needs Survey and the Caring Behaviours Inventory to generate a 28-item scale for compassionate care.	speaking patients, hospitalised for a minimum of 24 hours with an anticipated discharge within 24 hours after survey completion.	them rating the whole scale, giving a response rate of 70.8%.	unconditional love/respect, projecting their spiritual inner beauty, providing spiritual support, excuse shortcomings, provide connection to outside world, deal with difficult issues. *Patient expectations* encompassed pain control, timely treatments, checking frequently, there is a plan of care, presenting professional image. *Caring attributes* comprised, encouraging, appreciating patient and family, considering personal needs, being empathic. *Capable practitioner,* demonstrated competence, confidence, showing skill.	compassion and was developed amalgamating items from instruments that were originally designed to measure spiritual well-being and caring in general. Scale was developed to measure levels of compassion demonstrated by individual nurses providing care for patients in acute hospital settings. However, based on asking patients to rate how important each item was to them, rather than on asking them to rate the extent to which their carers behaved in this way. Inclusion of spiritual beliefs from a Christian perspective may limit generalisability of scale as not everyone holds themselves to Christian beliefs.	
Burtson and Stichler (2010) USA	Correlational study conducted at a 450 bedded academic medical centre. Used 4 instruments: Mueller McCloskey Satisfaction Scale (MMSS), Professional Quality of Life Scale (ProQOL), Stress in General Scale (SIG) and Caring Behaviours Inventory (CBI-24).	Convenience sampling. Target population n=450. Data collected over a 2-week period.	Actual sample of nurses n=126 (medical, surgical, emergency room, and intensive care units). Sample size met lower limits for the hierarchical multiple regression model.	Compassion satisfaction and opportunities for social contact with colleagues positively influenced care giving. Fostering nurses' internal motivation may increase frequency of caring behaviours and resulting patient satisfaction. Compassion fatigue was prevalent in the acute setting (particularly younger, less experienced nurses) and was correlated with burnout.	Justification of sample frame and representativeness is given. Majority of participants worked in medical-surgical units (n=91, 72.2%), added to a low overall return rate (28%) may have resulted in selection bias, and limited generalisability. Also predominantly female (88.3%). Variables were operationalised using valid and reliable research instruments. However, confounding variables related to participants themselves or organisational changes were not taken into account. Social desirability may have influenced self-assessment measure of caring behaviours.	MMAT 80%
Christiansen et al (2015) UK	Sequential explanatory mixed methods. Survey gathered structured data; interviews explored	Stratified purposive sampling. Conducted in a single university where all participants	Questionnaire completed by healthcare students (HCS) (n=197) and healthcare professionals	Four themes emerged, enablers to compassionate care were identified as: *Practising compassionately*; making emotional connections with the patient and families, *Individual and relationship factors*; personal resources to 'draw upon', own values, attributes and opportunities to reflect; *Leadership and*	Research conducted in single university; participant views may not reflect views of wider healthcare staff. Differing participant number quoted in abstract compared to body of study. Limited information on questionnaire development, structure, testing of content, and piloting.	MMAT 60%

	subjective experiences.	were undertaking academic and/or professional qualifications	(HCPs) (n=155). Total (n=352). Interviews conducted HCS (n=7) and HCPs (n=7). Total (n=14).	*team factors, supportive leadership and a collaborative team.* Barriers were identified as *Organisational factors*, time constraints, heavy workload, staff shortages challenging or aggressive patients and families.	Logistical difficulties cited for limited number of interviews. Lack of coherence between data presented, analysis and interpretation.	
Crawford et al. (2013) UK	Mixed methods. Corpus-assisted discourse analysis of semi-structured interviews. Followed by computational analysis of language that generated ranked word frequency lists.	Purposive sampling from 2 acute mental health units in one NHS trust hospital.	Acute mental health practitioners (n=20). Consultant psychiatrists (n=2); ward managers (n=2), ward sisters (n=2); staff nurses (n=8); 3rd year student nurse (n=1); healthcare assistants (n=5).	Findings indicated minimal evidence of compassionate language, emphasis on delivering process-focused rather than person-centred care. Participant responses focused on organisational barriers that impeded compassionate care. Relational attributes of feeling for patients and desiring to alleviate suffering less apparent. Language indicated an institutional mentality and emotional distancing between practitioners and patients.	Small sample size so findings not generalisable. Bias in qualitative interpretation was moderated by cross-disciplinary expertise across the fields of mental health and applied linguistics and quantitively through application of software identifying frequently occurring words and phrases. Results from computational analysis of language and interview data were integrated. Inconsistencies in findings not reported in detail.	MMAT 60%
Curtis, Horton and Smith (2012) UK	Grounded theory. In-depth interviews and NHS survey data from same geographical region as university was used to build contextual picture of student experience.	Convenience sampling and theoretical sampling. Participants recruited from a single university.	Student nurses, adult nursing (n=19), nurse teachers (n=5). NHS survey data from patients (n=72,000) and staff (n=290,000).	Students are influenced by (and learn from) personal, university and practice experiences yet professional socialisation result in similar concerns relating to compassionate practice. Students experienced dissonance between professional ideals and reality of practice. Manage this by balancing and adapting their ideals to conform to constraints. Support is required from practice and education to meet challenges. Important to foster student resilience.	Researchers did not work at university, avoiding potential bias. It is stated that participants were given the opportunity to member-check transcription data but does not state how many participants engaged in this. Students from both diploma and degree courses were involved but does not give number or potential influence, if any, this may have had on results. It is unclear if contextual survey data refers only to 'care' and this is then aligned to the results from interviews focusing on compassionate care.	Kmet, Lee and Cook 16/20
Curtis (2013) UK	Phenomenological study. In-depth interviews.	Convenience sampling through invitation letter.	Nurse teachers (n=5) at a single university.	Challenges to nurse teachers distilled into 3 themes: *Nurses changing role*, delegating bedside activities to healthcare assistants and time constraints in caring and mentoring activities; enabling student to learn while experiencing a dissonance between professional ideals and practice reality;	Researchers did not work at university, avoiding potential bias. Relatively small sample therefore results may not be transferable. Specific participant demographics and clinical practice backgrounds not specified. It is stated that participants were given the opportunity to member-check transcription	Kmet, Lee and Cook 14/20

				providing individual or small group work to provide emotional support, understanding of compassionate practice and to develop resilience. Need for strong leadership in practice to challenge constraints.	data but does not state how many participants engaged in this. Limited insight to theme development. The influence of researchers pre-existing assumptions, and strategies used to address these are not evident. Study limitations are not addressed.	
Dewar and Mackay (2010)* UK	Appreciative inquiry and action research. Part of fourth strand of LCCP focusing on development of compassionate care in clinical in-patient areas.	Four wards selected (termed Beacon Wards) that had demonstrated ways of working that exemplified a compassionate caring approach with staff, patients, and families.	Staff (n=10), student (n=9), patient (n=10), family (n=12) stories. Photo elicitation (staff n=16, patients n=2, families n=4). Totals - Clinicians (n = 35), patients (n = 12), families (n = 16)	Through observation of practices that worked well, stories and photo elicitation developed strategies that enhanced compassionate relationship centred care. 72 statements of positive caring practices developed; debated and redrafted on individual wards; matched to images, displayed at nurses' station. 'Caring conversation' meeting held daily to discuss statements and decide on action plans aimed at enhancing compassionate approaches to care.	No discussion of ethical issues. Selection of wards made by senior managers against criteria, how bias was overcome is not discussed. More detail of strategies to overcome the identified challenges of time constraints in implementing programme, to ensure participant understanding, would have been beneficial. Action cycle evaluated through observation, reflection, uptake of caring practice statements. Older person setting so limited transferability.	Kmet, Lee and Cook 16/20
Dewar et al. (2010)* UK	Appreciative Inquiry. Part of LCCP. Ward staff gathered patient and family stories/experience through interview using emotional touchpoints (key points in the patient journey).	Ward staff identified potential participants who were then approached by researchers to consent to participation.	Patients (n=16) and relatives (n=12) from a range of older person settings.	Use of emotional touchpoints to learn about compassionate care: Helps patients and families to engage with their own experiences: challenges staff assumptions; supports relationship development with patients, families and staff; balances positive and negative aspects of patients experience; promotes patient involvement in shaping and improving service. Requires raising the profile of emotional work at organisational level.	No pilot study reported. Predominantly older person care settings, therefore transferability limited. Little insight given to format and patient numbers involved in 'general discussion' and short interviews to develop range of emotional touchpoints/words for use with participants. Selection of participants was made by staff, no explanation given of how selection bias was overcome. Each participant engaged with member-check transcription of interview data to ensure accuracy.	Kmet, Lee and Cook 16/20
Dewar and Nolan (2013)* UK	Appreciative inquiry. Part of LCCP. Study took place on a 24 bedded	Purposeful sampling. Ward was selected in LCCP as	Registered nurses, non-registered nurses, allied health professionals and	Study demonstrated that engaging in *appreciative caring conversations* promotes compassionate, relationship-centred care. From results a model was created called the 7 C's that identifies	Older person setting so limited transferability. Selection of wards made by senior managers against criteria, how bias was overcome is not discussed.	Kmet, Lee and Cook 15/20

	mixed-sex ward for older people. Data collection methods: observation, interviews, storytelling, and group discussions.	demonstrated ways of working that exemplified a compassionate caring approach with staff, patients, and families.	medical staff were included (n=35). Patients (n=10) and family members (n=12).	factors necessary to promote '*appreciative caring conversations*.' 7 essential attributes underpinned conversations: being courageous, connecting emotionally, being curious, collaborating, considering other perspectives, compromising, and celebrating. To achieve compassionate relationship centred care staff require support, facilitation and strong leadership.	Identify the challenge of time constraints in implementing programme to ensure participant understanding, more detail of strategies to overcome this would have been beneficial. Findings linked to development of model and it is acknowledged that model requires further testing.	
Dewar and Cook (2014)* UK	Part of LCCP. Mixed methods study using a culture questionnaire and semi structured interviews. Involved 6 communities of practice, action learning sets and work-based activities.	Purposeful sampling.	Associate Directors of Nursing (n=2), Clinical Nurse Managers (n=5), Charge nurses/ward managers (n=23), Senior staff/registered nurses (n=23), Staff/registered nurses (n=33). Total (n=86), covering 24 in-patient areas within one hospital.	Leadership programme built on 3 theoretical principles: inquiring appreciatively (what works well and build on this), relationship centred practice (creating positive relationships), and experience-based design (participants seek out and value experiences of service users to develop practice). Participants engaged in caring conversations (Dewar and Nolan 2013) and used emotional touchpoints (Dewar et al. 2010). Results identified programme offered opportunity for staff to examine compassionate practices that worked well, enhanced self-awareness as leaders, developed creative ways of relationship building that influenced caring. Identified supportive organisational structures and systems are necessary for leadership development.	No discussion of ethical processes. Justification not given for action learning sets being 'band' specific. Assessment of programmes impact was completed through a staff culture questionnaire; ongoing reflections, staff reported developments, case studies, staff interviews. The origin/development of the staff culture questionnaire is not identified and statistical data from the questionnaires is not presented. Qualitative results from the interviews are discussed under themes. It is stated that staff interviewed each other at the end of the programme (the interview questions are identified), however preparation of staff and post interview support should issues be raised that required further support is not discussed.	MMAT 60%
Dixon-Woods et al (2013) UK	Large scale mixed methods study involving seven separate sub studies. Both quantitative and qualitative approaches to analysis.	Purposive sampling.	107 interviews with senior level stakeholders; 197 interviews involving both executive staff and clinicians. 650 hours of ethnographic observation. 715	Found almost a universal desire to provide the best quality of care. However, inconsistency of high-quality care, challenged by unclear goals, overlapping priorities and compliance-oriented bureaucratic management. Poor organisational and information systems left staff struggling to deliver care effectively and disempowered them from initiating improvement. Organisations	No evidence of pilot study. Lacks detail of recruitment strategy. Researchers acknowledge due to scale of study difficult to report full details. Patient and public involvement survey consisted of 14 statements with open text box provided for each statement. The development of the survey questions is not discussed.	MMAT 80%

			survey responses. 2 focus groups. Team process and performance data from 621 clinical teams. 793 sets of minutes from 71 NHS trust boards.	need clear and explicit goals, feedback from patients and staff, as well as formal data collection, identifying how well they are really doing and how they can improve. Need to review and improve organisational systems and nurture caring cultures ensuring staff feel valued, respected, engaged, and supported, both as individuals and within teams.	Detail of methods of analysis identified, including correlation analysis between data. Synthesis of findings was interpretive and narrative not using formal protocol, consequently dissimilar interpretations of data, and subsequent conclusions could be reached.	
Fry et al. (2013) Australia	Ethnographic study. Involved non-participant observations of Clinical Initiative Nurses (CIN) in 3 emergency departments. Observational data was analysed using thematic analysis.	Purposive sampling. Inclusion criteria: 2 years of emergency experience, worked in CIN role for more than one year.	Emergency CIN's (n = 16)	Essential elements of CIN role were centred on compassionate caring enabled through interpersonal skills. Embodied through a combination of physical, perceptual and behavioural actions. Organisational pressures impact negatively on nurses' ability to engage in compassionate care, resulting in increased emotional labour. A culture of care supported by teamwork, facilitates professional socialisation that can create optimum care opportunities for patients.	Formed part of a larger qualitative exploratory study of the CIN role. Focus on experienced CIN's may have revealed more experienced viewpoints if compared with less experienced practitioners. 13 females and 3 males in sample, research did not consider impact of gender. Influence of researchers on participants and process of data collection is not discussed.	Kmet, Lee and Cook 13/20
Graber and Mitcham (2004) USA	Phenomenological approach. Involved two hospitals, one 500 bedded academic medical centre and a 140 bedded religious affiliated community hospital. Semi-structured interviews used.	Purposive sampling.	Hospital clinicians (n = 24) Nurses (n=10); nursing aides (n=1); physicians (n=6); physical therapists (n=4); occupational therapists (n=1); dentist (n=1); child life specialist (n=1).	Identified specific relational skills essential in providing compassionate care: getting to know the patient, feeling the patient's suffering, identifying with and liking patients, and demonstrating respect. Identified personal experiences within and outside of their formal healthcare training as key contributors to their capacity for compassion The notion of emotional resonance, the ability to develop warm and empathetic relationships with patients and not distancing themselves from patients' emotions were associated with increased job satisfaction and retention.	Study is based on a small regional sample therefore limited transferability. Participants identified by administrators as being exemplary in caring and compassion, nominations reviewed by senior clinical managers. Consequently, bias may have been involved. Semi structured interview included questions about participants religious and spiritual practices, and how these beliefs might influence interactions with patients thus influencing the results. Researchers engaged in reflexivity with research team, in 'bracketing' interviews and peer debriefing to address possible biases.	Kmet, Lee and Cook 15/20
Horsburgh and Ross (2013)*	Grounded theory.	Purposive sampling.	7 focus groups of NQ nurses within their first year of	Identified transfer from student to NQ is stressful and six themes emerged*:;* *Expectations versus reality* - inadequately	Part of a 3-year action research programme (LCCP).	Kmet, Lee and Cook

UK	Focus groups. Formed one strand of the Leadership in Compassionate Care Programme (LCCP) exploring support for newly qualified (NQ) nurses in first year of registration. Research took place during 4-6 study days.		registration from a range of settings, total participants n=42. No differentiation was required in relation to experience within timeframe, field of nursing, or practice location.	prepared to provide compassionate care once they transitioned into clinical practice; *Preparation for practice* – education should focus on reality of being a staff nurse rather than an idealised view; *Support in practice* – rather than structured more reliant on good will; *Ingrained in the woodwork,* existing staff negativity *and a negative workplace culture* (e.g. resistance to change, entrenched views, negative staff attitudes) impacts on provision of compassionate care; *conceptualisation of compassionate care* identified integral to nurse/patient and staff relationships however often contextualised through reference to situations when it is absent.	No insight given to numbers of NQ nurses that did not participate. No claim to transferability of findings. Influence of researchers on participants and process of data collection is not discussed. Stated aim of study to explore NQ nurses' perceptions of, and factors that influence, compassionate care, majority of finds focused on transition from student to NQ nurse. Stated six themes emerged in findings however identification of the individual themes was less than clear.	16/20
Hunsaker et al. (2015) USA	Descriptive and predictive study using self-report survey. Measures: Demographics survey and Professional Quality of Life Scale Version 5	Purposive sampling. 1000 surveys mailed to ED nurses nationwide.	Survey returns (n=284) 28% response rate. Staff working fewer than 8 hrs removed (n=6). Resulted in total survey participants n=278. Inclusion criteria - must work at least 8 hours per week interacting directly with ED patients, and have at least one year of experience in ED.	Low to average levels of compassion fatigue (CF) and burnout were reported with low manager support being a significant contributing factor. Managers should aim to create a professional environment that promotes teamwork and positive working relationships. Average to high levels of compassion satisfaction (CS) were reported. Participants mean age was 44 years (SD=11.47), years working as nurse ranged from 1-48 (mean =17.58, SD=12.67)), results showed the older the nurse at time of survey, and longer in practice, the higher the level of CS.	Sampling strategy appropriate, however small sample as purpose of study was to determine the prevalence of CS, CF, and burnout in ED nurses throughout the USA. Results not generalisable, prevalence of CS, CF, and burnout was measured at a single point in time therefore this could change over time. ED nurses' perceptions are subjective, affected by variables not examined in study. Participants all belonged to ED professional organisation, which may have influenced results.	MMAT 80%
Jones et al. (2016) Australia	Qualitative descriptive. Nurses reflected on experiences during 'compassion cafes.' Results	Purposive sampling.	All nursing staff working within a single Intensive Care Unit participated in workshops (n=191).	The findings identified enablers to compassionate care as support from managers; senior staff acting as role models; supportive team relationships; and building a rapport with patients and families. Barriers were identified as not having time to connect with the patient;	Method rather than methodology discussed. Sticky notes were used in 'Compassion cafes' reflecting on enablers and barriers, then thematically analysed. A limitation was the brevity of content raising issues of	Kmet, Lee and Cook 10/20

	were thematically analysed. Conducted within parameters of a continuing professional development initiative.		Participants then consented to inclusion of written contributions from workshops (n=171).	workload pressures; personal prejudices towards individual patients such as lifestyle choices resulting in an inability to build connections; confrontational attitudes and behaviour displayed by families; and individual nurses' social and family situation.	interpretation if the context of comments in the sticky notes was not established. Not clearly identified if nurse did not wish to participate how this would have been addressed. Researchers limited examination of own role and importance of reflexivity not addressed, thus impacting on confirmability.	
Kneafsey et al. (2015) UK	Exploratory, qualitative design. 9 focus groups.	Purposive sampling from one university (health and social care staff and students), 2 NHS hospitals, and from members of the public in the same geographical area as university.	Academic staff (n=13), healthcare students (n=12), clinicians (n=10) and service users (n=10). Total (n=45), female (n=42), male (n=3). Focus groups consisted of individuals from only one of the 4 groups. Recruited through poster display in public locations.	4 themes emerged: definitions of compassion; compassionate behaviours; barriers and threats, and ways to support compassion in practice. Participants identified style of communication, investment of time in developing a positive interpersonal relationship, and levels of personal engagement denoted compassion in the practitioner. Participants emphasised compassion should not be faked. A Framework for Compassionate Inter-Personal Relations was developed that involved: connecting, recognising feelings, becoming motivated, taking action to help, and sustaining relationships.	No pilot study reported. A research assistant led focus groups and was recruited independent of university and NHS hospital, removing potential bias. Small participant numbers in stakeholder groups and from a small geographical area, therefore, may impact on transferability of findings. Participants were predominantly female and volunteered to take part in the study which may have impacted on results.	Kmet, Lee and Cook 16/20
Kvangarsnes et al (2013) Norway	Hermeneutic phenomenological approach. 3 focus group interviews to gain perspective on compassionate care for patients with Chronic Obstructive Pulmonary Disease (COPD).	Purposeful sampling of intensive care unit (ICU) nurses at two hospitals.	Recruited face-to-face during work hours by one researcher. 2 nurses declined. ICU nurses (n=17) (female). Minimum of 2 years' experience caring for patients with COPD.	3 major themes and sub themes: *Preparing to care for breathlessness*; creating a caring environment, ensuring co-operation, competence in actions. *Establishing a trusting relationship*; creating a sense of safety, compassionate treatment, alleviating pain, balancing treatment with sleep and rest. *Treating the patient as a person*: meeting the patients' fear, protecting patients' autonomy, sensitive-assisted personal body care.	Subset of a larger research project. No pilot reported. Small sample size may impact on transferability. All female therefore challenges representativeness. Nurses recruited from 2 hospitals but does not identify numbers from each hospital, and if focus groups included only nurses from one hospital or across both. Culture within each hospital could have influenced results. Two researchers were ICU nurses and potential impact of their positions and pre-understanding is acknowledged and addressed in field notes and reflexive text.	Kmet, Lee and Cook 16/20

				Emphasises importance of holistic patient-centred approach within a professional community.	At the end of interviews the researcher summarised the discussion to participants to confirm agreement.	
MacArthur et al. (2017) UK	Qualitative, longitudinal design. Realistic evaluation framework to analyse impact of the LCCP. Data collection in 3 phases. Methods used: semi structured interviews, informal observation, review of outputs from LCCP team, attendance at LCCP meetings.	Purposive sampling.	Total participants across the 3 phases: Charge nurses and nurse managers (n=20); senior nurses within LCCP (n=7); senior individuals in NHS organisation and higher education institution (n=5).	Findings: varying levels of adoption of the LCCP. High levels of adoption resulted in positive outcomes indicating key elements related to the provision of compassionate care (4 wards). Low/medium levels of adoption patient experiences less positive and outcomes more limited (3 wards). Level of adoption reflected continued engagement with LCCP, one indicator was long term use of emotional touchpoints Dewar et al. (2010)*. Leadership emerged as the most significant factor influencing sustainability of the LCCP. Conceptual model developed of factors that can embed compassionate care in health care environments.	Perspectives of patients and relatives drawn from secondary rather than primary data. Taken from perspectives of senior and charge nurses during interviews, and from analysis of LCCP findings. Consequently, reliant on secondary interpretation of patients' views. The study was conducted concurrently to the implementation of the LCCP allowing detailed inquiry using a variety of participative methods and semi-structured interviews. LCCP was conducted in a single health board this could have influenced the overarching organisational culture which makes generalisability of the findings challenging.	Kmet, Lee and Cook 16/20
Papadopoulos et al. (2016a) International study.	Exploratory, cross-sectional descriptive study. On-line survey developed by principal investigator (The International Online Compassion Questionnaire). Survey consisted of 10 open and closed questions.	Pilot survey conducted with nurses (n=74) in South Korea, survey modified to enhance clarity. Final research - opportunistic, snowball sampling approach. Link to survey emailed to co-researchers	Participants (n=1323) recruited across 15 countries. 12 of the 15 countries exceeded initial aim of 50 participants. Survey completed on-line by final year nursing students (n=131), practising nurses (n=600), lecturers/nurse educators/nurse managers (n=387). Participants (n=295) did not	Findings indicate that the individuals cultural background and experience impacts on their views and how they define compassion. Despite differences of definition of compassion there was similarity in identification of importance of compassion in nursing practice and the negative effects of organisational pressures, such as time available; organisational cultures that prioritise efficiency, and a lack of compassion from their managers. 25% of the participants expressed that they would be caring and compassionate in practice with or without specific training, however the majority believed that it is a skill that can be developed during training.	Results of pilot study identified. The selection of countries involved was dictated by the networks of the lead researcher, as a result, European countries dominate the sample (9 out of 15). Recruitment of participants was carried out through co-researchers from each country consequently sampling techniques may have led to selection bias. Face and content validity were improved by co-researchers from each of the 15 countries commenting on questionnaire and it was modified to improve cultural relevance (capturing participants ethnicity, job roles, translated into native language using WHO guidelines). First-time questionnaire had been used therefore reliability not established. Study identified that participants (n=295) did not state role or identified as other	MMAT 60%

		who distributed to relevant groups and networks.	state role or identified as other. Eligibility dictated by above roles. Participants who could not access on-line version were sent hard copy.		however appear to be included in some data sets (Table 3). Individual cultural differences and similarities not reported as analysis was performed at country level.	
Papadopoulos et al. (2016b) International study.	Exploratory, cross-sectional descriptive study. Data drawn of Greek and Greek-Cypriot participants from large scale study (Papadopoulos et al. 2016a). The International Online Compassion Questionnaire consisted of 10 open and closed questions	Snowball sampling. Link to survey emailed to co-researchers who distributed to relevant groups and networks.	Qualified nurses, nurse teachers, senior student nurses. Greek (n=94), Greek Cypriots (n=49).	Greek and Greek Cypriot nurses define compassion differently however perceptions of how compassion is implemented in practice are similar. Participants understood and enacted compassion in 3 ways: compassionate communication, awareness of the needs of patients, and as acts of kindness. Identified that they received little compassion from management. Identified there is an urgent need for compassionate leaders. Agreed compassion can be taught but identified not enough teaching is presently provided.	Background to selecting Greek-Cypriot participants from a historical and cultural perspective and difference in healthcare systems is discussed. Unequal sample sizes (Greek and Greek Cypriot nurses) result in difficulty with generalisability. The conclusion that compassion is defined differently is therefore challenging. Snowball sampling may result in bias.	MMAT 60%
Perry (2009) Canada	Descriptive phenomenology. Data sources, participant observation field notes, and individual unstructured interviews.	Purposive sampling.	Registered Nurses (RN) and licensed practical nurses (total n=7).	Findings revealed overarching theme of 'attention to the essential ordinary' achieved through 'attention to the little things' (compassion is conveyed in the smallest actions) and 'keeping the promise to never abandon' (staying present with the patient through traumatic experiences and difficult moments).	Small sample size therefore participants may not have been representative of larger nurse population. Participants volunteered consequently may have impacted on results. Participant numbers of RN's and licensed practical nurses not identified. How researchers addressed impact of their own experiences and bias was not discussed.	Kmet, Lee and Cook 12/20
Schantz (2007) USA	Concept analysis using Walker and Avant's methodology.	N/A	N/A	Identifies the concept of compassion is lacking in nursing literature. Challenges the use of other concepts such as caring, sympathy, empathy used interchangeably with compassion when meanings differ. Identifies the empowering nature of	Moral dimension of compassion is explored and the antecedent of suffering. The conclusion does not clearly specify the meaning of compassion through definition, or the attributes involved in providing compassion and compassionate care.	

				compassion and the importance of small gestures.		
Sinclair et al (2016a) Canada	Grounded theory. This study is a subset of a larger study (Sinclair et al. 2016b). A literature review was conducted (Sinclair et al. 2016c); gaps were identified related to compassion training. Interview guide developed from this and used in semi-structured interviews.	Purposive and theoretical sampling of advanced cancer inpatients, a life expectancy of less than 6 months.	Advanced cancer inpatients (n=53) Eligibility criteria: at least 18 years of age, able to speak and read English, an incurable cancer diagnosis, no demonstrable signs of confusion. Stated reported in Sinclair et al (2016b).	Findings identified 3 overarching categories: compassion aptitude, cultivating compassion, and training methods. Participants believed: Learners capacity for compassion was partially dependent on innate attributes. Vocational motivators (financial are career advancement) and life experiences inhibited or facilitated compassion. Supportive teaching environment. Cultivating compassion required core competencies: building a relationship, understanding the patient as a human being, and developing a connection (emotional resonance). Three training methods suggested: person-centred communication skills, reflective practice, compassionate role modelling.	Rationale given for performing secondary analysis on data as reducing burden on palliative care patients participating in multiple studies. Participants recruited by members of palliative care team consequently there may have been selection bias. Stated interview guide was revised after 10 interviews and again after 23 interviews, only one example of revisions is provided. Methods of data analysis discussed clearly. 72% of participants had experienced university education consequently they have awareness of a range of teaching and learning methods, this may have influenced results. Examples of data coding not given. Generalisability of findings is limited as focused on palliative care setting.	Kmet, Lee and Cook 16/20
Sinclair et al (2016c) Canada	Grounded theory. To investigate palliative cancer patients understandings and experiences of compassion. Conducted semi-structured interviews. Data were analysed through three stages of coding.	Convenience and theoretical sampling, of advanced cancer inpatients recruited over a seven-month period from a palliative care unit palliative care consult service in a single hospital.	Advanced cancer inpatients (n=53) Female 35%, male 65% (numbers presented as %). Eligibility criteria: able to speak and read English, an incurable cancer diagnosis, a life expectancy of less than 6 months. Potential participants (n=151) referred by palliative care staff, n=98 deemed ineligible.	The key elements of compassion emerging from the data generated 7 categories, each containing distinct themes and subthemes. 7 categories were conceptualised within an empirical model: *virtues* of healthcare provider; compassion delivered in a *relational space* involving patient awareness and engaged caregiving; *virtuous response*, knowing the person, prioritising the person, and beneficence; *seeking to understand,* the person and their needs*; relational communicating,* verbal and nonverbal displays of compassion conveyed through demeanour, affect, behaviour and engagement*; attending to needs,* timely and attuned desire to actively engage suffering*; and patient reported outcomes,* alleviating suffering,	Limited discussion about ethical stages. Stages of data analysis and coding discussed. Participants recruited by members of palliative care team consequently there may have been selection bias. The focus and participants are from a palliative care setting cared for by an interdisciplinary palliative care team, their perspectives may not be indicative of noncancer patients. Generalisability of findings is limited. Interviews were based on retrospective experiences therefore participant recall may have influenced results.	Kmet, Lee and Cook 16/20

				enhancing wellbeing, and enhancing care.		
Sinclair et al (2016d) Canada	Grounded theory. Data collection using semi-structured interviews and a demographic questionnaire. Data were analysed through three stages of coding.	Purposive sampling.	151 eligible patients were referred by palliative care staff. Final participants numbers (n=53). Female 35%. Male 65%. Eligibility criteria: able to speak and read English, incurable cancer diagnosis, life expectancy of less than 6 months.	Constructs of sympathy, empathy and compassion are used interchangeably in literature however patients experience them uniquely. Each contain distinct themes and sub-themes. Sympathy – unwanted, pity-based response, motivated by pity, ego and obligation. Empathy – acknowledges and attempts to understand suffering through emotional resonance motivated by affective state of practitioner and a sense of duty. Compassion - enhances key facets of empathy, motivated by inherent virtues of practitioner generating a virtuous response leading to action aimed at relief of suffering.	Research nurse conducting interviews was both independent of host hospital, employed specifically for purpose of study and not involved in data analysis reducing bias. Participants recruited by members of palliative care team consequently there may have been selection bias. 59% of participants were retired, 72% had experienced university education, and all were palliative care patients consequently this would impact on generalisability. Examples of data coding not given.	Kmet, Lee and Cook 16/20
Sinclair et al. (2018) Canada	Grounded theory. Data gathered from focus groups and semi-structured individual interviews. To investigate healthcare providers perspectives and experiences of compassion.	Healthcare providers (HCPs), nominated exemplary HCPs, and key stakeholders recruited through convenience, snowball and theoretical sampling.	Healthcare providers (n=57) recruited from urban and rural palliative care services. Eligibility criteria: at least 18 years of age, able to speak and read English, worked in palliative care for at least 6 months, able to provide written consent	5 categories and 13 associated themes identified. 5 categories: virtuous intent; relational space; coming to know the person, forging a healing alliance, and ameliorating suffering. Compassion was conceptualised as a virtuous and intentional response to know a person, to discern their needs and ameliorate their suffering through relational understanding and action. From results created empirical model of compassion depicting dimensions of compassion and their relationship to one another.	Research nurse conducting interviews was employed specifically for purpose of study and not involved in data analysis, reducing bias. Exemplary compassionate care providers were nominated from focus group participants via a single question on demographic questionnaire. This question is not stated. Individual bias may have influenced nomination. 1st stage HCPs participated in focus groups (n=35), 2nd stage individual interviews (n=15). Final stage 2 focus groups HCPs (n=5) and key stakeholders (n=10) involving stage 1 and 2 participants. Consequently, difficult to align these numbers with total number of participants. Nurses formed largest group of participants (n=26). Other professionals/staff represented by small numbers e.g., one social worker, one housekeeper, one	Kmet, Lee and Cook 16/20

					psychologist, therefore may not be representative.	
Singh et al. (2018) Canada.	Grounded theory. Data collected through focus groups and semi-structured interviews.	Convenience, snowball and theoretical sampling.	Healthcare practitioners (HCP's) (n=57) from three palliative care Settings. inclusion criteria: at least 18 years of age, able to speak and read English, worked in palliative care for a minimum of 6 months, and able to provide written consent.	2 categories identified: *Challenges to compassion* and *Facilitators to compassion.* *Challenges*: personal (innate virtues and motivators could impact positively or negatively), relational (personal prejudices, stigmatisation of patients), systemic (organisational demands, time constraints) and maladaptive (difficult patients, occupational stressors). *Facilitators*: personal (self-care, own personal feelings experiences of suffering), relational (expressions of gratitude by patients and relatives, building relationships), systemic (supportive colleagues, leaders committed to compassion, organisational values that reflected compassion) and adaptive (intentional acts of compassion).	The study could have provided more detail about its association to research by Sinclair et al. (2018). When comparing the two studies, the timing, demographic information and data collection methods are identical. From the study by Sinclair et al. (2018) an empirically based clinical model of compassion was developed, codifying the key elements of compassion. The aspects of the model describing the facilitators and challenges are presented in this research (Singh. et al. 2018). et al. 2014; Jones et al. 2016). The results from palliative care settings may not be transferable to other areas of healthcare. Sample may not have been representative of all palliative care providers.	Kmet, Lee and Cook 16/20
Smith et al. (2014)* UK	Part of LCCP. Action research. Used format of 4 'restorative space workshops' (with lecturers) facilitating reflective discussions about educational practice and organisational experience of compassion in the workplace. Data collected in the form of collages, field and reflective notes.	Purposive sampling.	Senior lecturers (n=2), academic developer (n=1), lecturers (n=2), practice educator facilitator (n=1), senior nurses from LCCP (n=2). Total (n=8).	3 themes related to compassion in the workplace: *leadership*, lecturers believed there was little time to evaluate processes, difficult to align individual values with HE vision, lack of influence in decision making; *culture*, importance of respecting each other, supporting development and celebrating successes, clarity of workload; *professional and personal development*, control over workload activity, sources of support, feedback and opportunities for reflection, workshops offered opportunity for own learning. Consequence of this research, lecturers within the school were given opportunity to participate in leadership development.	This research focused on the undergraduate nurse education strand of the LCCP. Introduction to paper suggests focus groups involved lecturers and student nurses, however only educational staff involved. Small sample size therefore experiences may not be representative of all lecturers. Facilitators (n=4) were also participants, actively involved in workshop activities, this may have influenced results.	Kmet, Lee and Cook 14/20

Sumner (2006) USA	Concept analysis: The Moral Construct of Caring in Nursing as communicative Action (MCCNCAT). Utilised Morse's (1995) method of analysis, applying qualitative techniques to develop the concept of caring in nursing for instrument development.	N/A	N/A	Concept analysis explored interrelated concepts, specifying their relationship, and creating an operational definition of caring in nursing for instrument development. Identified that the nurse and patient function in a unique social world to which each brings their lifelong experiences, values and beliefs, education, and expectations of the other. Framed each interaction between nurse and patient as having two components. The nurse has personal self and professional self and the patient has personal self and illness self. Proposed that nursing is a moral, bi-directional activity between the nurse and patient which is characterised by care and compassion.	The strength of this analysis is the emphasis on the bidirectional communication underpinning the nurse patient interaction, how the needs of both are met, highlighting their vulnerability and need for considerateness. Consequently, offering clarification of the uniqueness of caring in nursing, because of the specific communication between the assumed roles of nurse and patient, who are delimited by the healthcare delivery system and the pathophysiology of health and illness.	
Sumner (2008b) USA	Critical Social theory. Examining healthcare delivery system in 3 countries; USA; New Zealand and UK. Data collected via interviews.	Convenience sampling. All participants worked in acute care hospital practice.	Nurses (n=10), female (n=9); male (n=1). Inclusion criteria, baccalaureate degree or equivalent and less than 5 years practice experience.	Emerging themes; *being normal* (the nurses humanness and that of their patients), importance of *little things* (expertly provided to patients), *hardness of nursing* (emotional involvement, one's compassion can lead to hurt), *relationship as human-to-human connection* (importance of relationship building involving rapport and respect), *practice organisation* (effective time management and organisation enabled nurses to attend to patient's needs), *malcontent* (frustration at hierarchy, system constraints, negativism of other nurses), *power and control* (organisational power and lack of insight of nursing power in patient interactions).	Recruitment of participants not discussed. Small sample size therefore generalisability is limited. Participants were predominantly female, numbers related to country not specified and stated as 'white', therefore cultural origin not apparent. Clear justification for use of methodology is given and the theoretical importance of reflexivity. Influence of researcher not discussed. Data collection and data analysis methods not described in detail. Issues of trustworthiness and credibility of results not discussed in detail.	Kmet, Lee and Cook 14/20
Sumner and Fisher (2008) USA	Theory testing using Rasch model. Instrument and data testing of the	Convenience sampling. 185 item instrument was administered	Total surveys completed (n=82) from USA (N=32), New Zealand (n=30), UK (n=12), identified	Instrument developed to test MCCNCAT. Results delineated components of nursing to include 'personal self' of nurse and patient, and 'illness self' of patient occurring in the interaction between nurse and patient. Data confirms	Overall sample size was small resulting in inability to study invariance of scale across demographically different subsamples of participants. Generalisability is limited. 185 questions in survey may have deterred completion.	MMAT 60%

	Moral Construct of Caring in Nursing as Communicative Action Theory (MCCNCAT).	to nurses across 3 countries (USA, New Zealand, and UK).	as attended conference declaring country of origin as 'other' (n=6), did not declare country of origin (n=2).	interaction is bidirectional, confirming caring as moral bidirectional communication between nurse and patient. Nurses recognise that they are as vulnerable as the patient and need 'consideration'.	Validated and reliability tested measures are used. Ethical approval processes not discussed. MCCNCAT focuses on nursing as bidirectional interaction therefore further testing with patient involvement would contribute to evaluation.	
Van der Cingel (2011) The Netherlands.	Grounded theory used to determine specific research questions. In addition, constant comparative analysis was applied in phases of data collection and analysis. Data collected from in depth interviews.	Purposeful sampling. Eligibility criteria: patients were 65 years of age or older and able to express themselves in Dutch. Nurses had to have a minimum of 5 years' experience in nursing.	Nurses (n=30) and patients (n=31) were interviewed using semi-structured interviews. Data was collected from 2008-9 in three settings, rehabilitation, a home care organisation, and outpatient clinics.	A theoretical framework was developed consisting of five 'issues'; compassion and suffering; compassion and identification; the emotion compassion; motives for compassion; and the moral significance of compassion. The nature of compassion has 7 dimensions demonstrated from nurse to patient: *attentiveness* (conscious approach supported by gestures or touch); *listening* (active listening to really hear another's story); *confronting* (through emotional validation acknowledging that the patients emotions are rightly felt); *involvement* (nurse recognises emotion and shares concern with patient); *helping* (assisting in activities of daily life by responding and anticipating); *presence* (to be there through conscious choice); and *understanding* (demonstrate intention you are trying to understand).	The researcher and three nursing students conducted the semi-structured interviews. Although interview training was given there is no clarification if students were known by participants as this may have influenced results by preference bias. Patients were nominated by a nurse consequently there is risk of selection bias. A previous literature review informed the structure of the interview questions and may have influenced participants in their individual phrasing of views on compassion. Research focused on older people with chronic disease therefore generalisability is limited. Data transcription was performed by research assistant outside the research setting adding to reliability.	Kmet, Lee and Cook 16/20
Way & Tracy (2012) USA	Qualitative field study, focusing on employee viewpoints and workplace activities in two 'for-profit' hospices. Data gathered over 6 years. Data sources, participant observation field	Stated lead researcher had full research access allowing open participation with patients, families, employees.	2 hospices. Total participants (n=96): nurses (n=32), aides (n=23), social workers (n=14), spiritual providers (n=4)and others (n=23) (staff, maintenance workers, doctors). 67 participants were observed for	Re-conceptualised compassion, identifying three components: recognising (understanding and applying meaning to communicative cues), relating (connecting with another to enable sharing of emotions, values and decisions), and re-acting (engaging in behaviours or communicating in a way that is recognised as compassionate). Findings demonstrate compassion is a relationship involving cognitive connecting and affective feeling required to facilitate communication and	Lacks detail on differing participant characteristics. Consent to participate and further ethical issues not discussed. Structure of formal interview questions are not made explicit. Method of analysis is discussed with development of coding and theme development. However, origin of data not always made evident in text e.g. from interview, field notes, observation. Approaches to reliability and validity not discussed.	Kmet, Lee and Cook 14/20

	notes, informal ethnographic interviews, transcribed structured interviews.		extended period and/or formally interviewed, 29 briefly observed or informally interviewed. 75% female, 25% males.	understanding. Compassion also involves compassionate action as giving others the gift of quiet, time, and space. Compassion was associated with increased job satisfaction. Created a visual model to represent the processes of compassionate communication.	Approaches of researcher to reflexivity not made evident consequently background and assumptions may impact on dependability and confirmability.	
40	37 studies / 3 concept analyses					

Appendix 3 – Reporting the results of the MMAT (version 2018)

Scoring of quantitative studies using the Mixed Methods Appraisal tool (MMAT)

Studies	Criteria for the Mixed Methods Appraisal Tool																								
	Qualitative					Quantitative randomised controlled trials					Quantitative non-randomised					Quantitative descriptive					Mixed methods				
	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5
Bray et al. (2014)																					1	0	1	0	1
Burnell and Agan (2013)																1	1	1	0	1					
Burtson and Stichler																1	1	1	0	1					
Crawford et al. (2013)																					1	1	0	0	1
Christiansen et al. (2015)																					1	1	1	0	0
Dewar and Cook (2014)																					0	1	1	1	0
Dixon-Woods et al. (2014)																					1	1	1	0	1
Hunsaker et al. (2015)																1	1	1	0	1					
Papadopoulos et al. (2016a)																0	1	1	0	1					
Papadopoulos et al. (2016b)																0	1	1	0	1					
Sumner and Fisher (2008)																0	1	1	0	1					

In the 2018 version the use of metrics to score studies was discouraged as it was believed by presenting a single number it was not possible to know what aspects of studies were problematic. It was recognised that this presented challenges in reporting results. Consequently, the revised suggestion is that, as there are only a few criteria for each domain, the score can be presented using descriptors such as %

Reporting the results of the MMAT (version 2018 Hong *et al.*, 2018)

In the version 2018, we advised not to present an overall score. This decision was made from the literature that discouraged to use metrics because it is not informative. By presenting a single number, it is not possible to know what aspects of studies are problematic. We often see people presenting a global score and nothing else in the results or discussion or description of included studies. This often raises the question of why quality appraisal was performed.

This suggestion is, however, problematic for reporting the results of the MMAT. Several MMAT users have contacted us for advice to report their results. If there is a need to report an overall score, here is a suggestion based on the previous version of the MMAT:

For each retained study, an overall quality score may not be informative (in comparison to a descriptive summary using MMAT criteria) but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as stars (*) or %:

5***** or 100% quality criteria met
4 **** or 80% quality criteria met
3 *** or 60% quality criteria met
2 ** or 40% quality criteria met
1 * or 20% quality criteria met

For mixed methods studies, since there are 15 criteria to rate (instead of 5), the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 20% (*) when QUAL=1 or QUAN=1 or MM=1; it is 40% (**) when QUAL=2 or QUAN=2 or MM=2; it is 60% (***) when QUAL=3 or QUAN=3 or MM=3; it is 80% (****) when QUAL=4 and QUAN=4 and MM=4, and it is 100% (*****) when QUAL=5 or QUAN=5 or MM=5; (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).

Regarding questions on cut off value, we have not studied values that could characterize low, medium or high quality studies. The categories are arbitrary, but useful for performing qualitative or quantitative sensitivity analysis. We have seen some papers with 2 categories (lower vs higher quality) or 3 categories (e.g., low, medium, and high). What is important is to clearly describe how the results of the appraisal were interpreted and used in the review (transparency).

Examples of tables presenting the results of the MMAT:

Table presenting the ratings of each study

Studies	**Criteria from the Mixed Methods Appraisal Tool**																							
	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5
Author, date	0	1	1	1	1											1	0	1	1	1	1	1	1	1	1
Author, date											0	1	1	1	1										
Author, date						1	1	1	0	1															
…..																									

Table of characteristics of the included studies with a column on the overall score of each study

Studies	**Country**	**Population**	**Intervention**	**Comparator**	**Outcome**	**….**	**Quality**
Author, date							*****
Author, date							*
Author, date							***
…							

Appendix 4 – Summary of literature reviews

Author(s), year, and country.	Title and type of literature review	Method / findings	Discussion and conclusion	Critique
Blomberg et al. (2016) UK	"Interventions for compassionate nursing care: A systematic review"	Selected 24 studies reporting 25 interventions. Three types of intervention were identified: staff training (n=10) focused on development of new skills and knowledge in nursing staff; care model (n=9), focused on the introduced of a new care model to a service such as person-centred care; nurse support (n=6), focused on improving staff support and wellbeing.	The findings identified that intervention description was generally weak, lack of detail relating to participants and facilitators, and proposed strategies for change often unclear. Overall methodological quality of studies was low with most studies (n=16) conducted as uncontrolled before and after studies. Many interventions lacked theoretical foundation. Intervention descriptions not reported in sufficient detail with strong evidence of effectiveness to indicate value of implementation in practice. Most common type of intervention focused on training nursing staff despite evidence that deficits in relational care are not clearly linked to knowledge deficits, but to organisational barriers. No study reported sufficient detail of its intervention to enable replication and further evaluation.	Clear explanation of selection to analysis procedures. Cochrane Collaboration methods (Higgins and Green 2011) used to support analysis of review materials. An adapted Population-Intervention-Comparison-Outcome (PICO) framework guided study selection (Sackett et al. 1997). GRADE system (Guyatt et al. 2008) used to rate quality of evidence (rated as strong, medium or weak). Studies included randomised controlled trials (RCT's) and cluster RCT's. Studies were analysed against 26 item check list criteria for description of group-based behaviour change interventions (Borek et al. 2015).
Braithwaite et al. (2017) Australia	"Association between organisational and workplace cultures, and patient outcomes: systematic review",	62 articles included majority of studies (84%) were from North America or Europe and conducted in hospital settings (89%). They were largely quantitative (94%) and cross-sectional (81%).	Overall positive organisational and workplace cultures associated with a wide range of patient outcomes e.g., reduced mortality rates, falls, hospital acquired infections and increased patient satisfaction. Majority of studies used hybrid measures of culture in which both organisational and workplace culture were examined.	Clear explanation of selection to analysis procedures. The Quality Assessment tool (Hawker, Payne and Kerr 2002) was applied in evaluation of studies. High number of studies included, and multiple types of healthcare settings involved. Definitions and measurements of culture, environment, and patient outcomes were variable across studies, consequently limiting comparison.
de Zulueta (2016) UK	"Developing compassionate leadership in health care: an integrative review"	Strategies for developing compassionate healthcare leadership.	Development for compassionate leadership means fostering leaders who embody and enact the qualities of servant leadership: altruism, integrity, humility, and wisdom combined with appreciation and empowerment of others. Also training and well-being programmes are required. Tasks and relational care need to be integrated, creating opportunity for dialogue between patients, clinicians and managers.	There is no insight given to search strategy, range of methodologies, or framework for critical appraisal. A systematic approach to data analysis would have protected against bias, enhanced rigour, and ensured accuracy of conclusions.
Durkin, Gurbutt	"Qualities, teaching, and measurement of	21 papers identified (worldwide); few studies explored how compassion is	Identified a set of 11 globally recognised qualities for a compassionate nurse: *character, connecting to and knowing the patient, awareness of needs/suffering,*	There is clear explanation of the search strategy, and quality appraisal process. Kmet, Lee and Cook's (2004) *Standard*

and Carson (2018) UK	compassion in nursing: A systematic review",	taught to student nurses. Limited number of instruments for measuring compassion in nursing.	*empathy, communication, body language, involving patients, having time for patients, small acts in conveying compassion, emotional strength,* and *professional competence.* Recommended that the value of each characteristic be taught in nurse education using scenario-based training exercises, and a compassion scale incorporated into education programmes. Compassion scale could also contribute to selection process for nursing, assessing ability prior to commencing programme, developing compassion from baseline relative to individual. Concluded that presently construct and face validity of compassion scales is questionable therefore limiting effective measure of compassion.	*Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields*, and overview of scoring of studies was given. Interrater reliability scores were not identified. Only three studies related to how compassion is taught, and four studies to the type of instruments used to measure compassion in nursing, this may be the result of limited search terms.
Richardson, Percy and Hughes (2015) UK	"Nursing therapeutics: Teaching student nurses care, compassion and empathy", Discursive narrative review.	Objectives: Review of literature on caring, compassion and empathy. To understand the teaching and learning issues associated with these concepts. To design and implement an undergraduate unit of study which addresses the development of caring, compassion and empathy in student nurses.	Identified concepts of caring, compassion and empathy are interrelated and nebulous however health service users can detect these in nursing behaviours and attitudes. Identified to teach the development of therapeutic relationships a model is required. Selected Muetzel's model which incorporates three components: partnership, intimacy, and reciprocity. Used Muetzel's model for understanding therapeutic relationships as a framework for students to explore how they would exhibit caring, compassion and empathy whilst undertaking nursing interventions. Concluded that it is possible to develop materials to enable student nurses to learn how to build patient relationships and to care using compassion and empathy.	Data sources and search terms are identified. However, number of resulting research studies/literature, is not evident. There is discussion of the structure and relevance to therapeutic relationships of Muetzel's model. However, clear justification for the choice of this model rather than another is not given. Critical appraisal of research papers is integrated into discussion. Evaluation is ongoing.
Sinclair et al. (2016b) Canada	Compassion: a scoping review of the healthcare literature. Narrative synthesis of literature.	44 studies included: most originated in USA (n=21), UK (n=15) and published between 2010-2014. Methodological design: qualitative (n=23), observational (n=13), mixed methods (n=6); randomised controlled trials (n=2). Studies were divided into two groups: perspectives on compassion and compassionate behaviours (n=34), and	Identified limited empirical understanding of compassion in healthcare, highlighting lack of patient and family perspectives included in studies. Six themes emerged from studies that explored perspectives on compassion and compassionate behaviour: nature of compassion, development of compassion, interpersonal factors associated with compassion in the clinical setting, action and practical compassion, barriers and enablers to compassionate care, outcomes of compassionate care. Educational barriers identified as poor support within the practice area; a teaching environment that	Clear explanation of search strategy, eligibility criteria, study selection, results, data analysis, and evaluation. Used inductive coding to develop sub-themes and themes. Critical appraisal apparent in discussion of studies. Less than a third included patients.

		compassion interventions (n=10).	emphasised knowledge-based competencies resulting in a theory practice gap. Barriers within the practice setting included: lack of time; support, staffing and resources, increased paperwork with a focus on metrics and efficiency. Enablers included individual attributes and motivation, building a relationship with the patient, opportunities for reflection, and role modelling. 2 themes emerged from studies that explored compassion interventions: clinical interventions, and educational interventions.	
Sinclair et al. (2017a) Canada	Measuring Compassion in Healthcare: A Comprehensive and Critical Review. Comprehensive and critical narrative synthesis.	Nine studies contained information on Compassion Competence Scale, the compassion Scale, the Compassionate Care Assessment Tool and the Schwartz Center Compassionate Care Scale, the compassionate Practices Scale. Instruments assessed were associated with significant limitations.	Identified instruments measured aspects of compassion to varying degrees however no single measure, measured the construct comprehensively or applied a sufficiently methodologically rigorous approach. Also, lack evidence of adaptability to diverse practice settings. Compassion is identified as a key component of quality care which healthcare providers, educators and health systems are increasingly obliged to monitor. Consequently, need for a psychometrically validated instrument that comprehensively measures the construct of compassion in healthcare settings.	Clear explanation of search strategy, eligibility criteria, study selection, results, data analysis, and evaluation.
Sinclair et al. (2017b) Canada	Compassion fatigue: A meta-narrative review of healthcare literature.	Conducted using the Realist and Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES). 90 studies included.	Findings emphasised the physical, emotional, social and spiritual health of healthcare providers is impaired by cumulative stress related to work impacting on healthcare delivery. However precise nature of CF and that it is predicated on provision of compassionate care is associated with limitations. Identified conceptual analyses of compassion fatigue (CF) focus on limited facets of compassion (behaviours, motivators) and not the entire construct. Risk factors, antecedents, pathways, and manifestations of CF must be identified and based on valid model of compassion consistent and relevant across healthcare settings. Identified primary measure for compassion fatigue used in studies was Professional Quality of Life Scale (ProQOL) which does not provide a direct measure or assess all purported aspects of concept of CF (trauma	Clear explanation of search strategy, eligibility criteria, mapping for validity and relevance, study selection, results, data analysis, and evaluation. It could be viewed as limitation, as strength of evidence grading tool not used. Justification given that many research papers were theoretical and could not be meaningfully appraised by such tools. Mapping rather than appraising the quality of evidence was evident (RAMESES standards for evaluating meta-narratives).

			symptoms, cognitive distortions, general psychological distress, burnout). Concluded the concept of CF is a broad term for a family of occupational stresses attributed to healthcare providers, lacking construct validity and therefore difficult to measure. Risk factors for compassion fatigue include job related stressors; fewer healthcare qualifications and less years' experience.	
Sinclair et al. (2017c) Canada	Can Self-Compassion Promote Healthcare Provider Well-Being and Compassionate Care to Others? Results of a Systematic Review.	Meta-narrative review. Conducted using the Realist and Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES). 69 studies included.	The measurement of self-compassion is limited as the Self-Compassion Scale (SCS) (Neff 2003b) is the only known measure of self-compassion. Instrument was developed and validated with students therefore transferability to healthcare providers experiencing suffering requires validation. Major critique of studies investigating interventions on self-compassion is most lacked a control group. Also used SCS as a self-reported measure of self-compassion and reporting total score making it difficult to determine which subscale of SCS was most impacted by intervention. Self-kindness and self-care strategies are essential to sustaining wellbeing of healthcare provider.	Clear explanation of search strategy, eligibility criteria, study selection, results, data analysis, and evaluation. It could be viewed as limitation that strength of evidence grading tool was not used. Justification given that mapping rather than appraising the quality of evidence was more appropriate, (RAMESES standards for evaluating meta-narratives).
Strauss et al. (2016) UK	"What is compassion and how can we measure it? A review of definitions and measures"	2146 papers identified with only nine measures included: CCAT= Compassionate Care Assessment Tool; CLS = Compassionate Love Scale; CS-P= Pommier Compassion Scale; CS-M= Martins et al. Compassion Scale; RCS= Relational Compassion Scale; SCBCS = Santa Clara Brief Compassion Scale; SCCCS = Schwartz Center Compassionate Care Scale; SCS = Self-Compassion Scale; SCS-SF = Self-Compassion Scale — Short Form.	Lack of consensus on definition of compassion and following consolidation of existing definitions proposed that compassion has five elements: recognising suffering, understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings, and motivation to act/acting to alleviate suffering. Identified a paucity of psychometrically robust measures for this construct and all the identified measures were found to have notable psychometric weaknesses. Conclude that there is a need for a psychometrically validated instrument that comprehensively measures the construct of compassion.	Proposed definition does not encompass relational aspects of compassion and compassionate care. Clear explanation of search strategy, eligibility criteria, and study selection. Measures were rated across the domains of; content validity, factor structure, internal consistency, test-retest reliability, convergent and discriminant reliability. Quality rating ranged from 2-7 out of 14. Scales related to compassion for others and self-compassion were included yet stated that the relationship between the two is little understood.
10	5 – UK; 1 – Australia; 4 – Canada			

Appendix 5 – Constant Comparative Analysis – theme and sub theme development

Overarching Theme – Personal/relational issues	
Sub themes – Interpersonal factors; Communication; Relational factors.	
Interpersonal factors	
Personal values and beliefs. Impact of family upbringing. Personal experiences of suffering. Understanding and vulnerability derived from experience assisted provision of compassion. Motivation.	Graber and Mitcham 2004; Sumner 2006, 2008b; Sumner and Fisher 2008; Van der Cingel 2011; Way and Tracy 2012; Burnell and Agan 2013; Dewar and Nolan 2013; Christiansen *et al*. 2015; Kneafsey et al. 2015; Jones *et al*. 2016; Sinclair et al. 2016b, 2016d; Singh et al. 2018; Babaei and Taleghani 2019.
Communication	
Good communication skills. Personal attributes and behaviours. Verbal and nonverbal communication Communication and collaboration among different professions	Sumner 2006, 2008b; Sumner and Fisher 2008; Perry 2009; Dewar and Mackay 2010; Dewar et al. 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Crawford et al. 2013; Dewar and Nolan 2013; Horsburgh and Ross 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Kneafsey et al. 2015; Jones *et al*. 2016; Papadopoulos et al. 2016b; Sinclair et al. 2016b, 2016c, 2016d, 2018; MacArthur et al. 2017; Durkin, Gurbutt and Carson 2018; Singh et al. 2018; Babaei and Taleghani 2019.
Relational factors	
Connecting to the unique needs and experiences of the patients and their suffering. Collaborating with the patient and their relatives/carers. Demonstrating respect, willingness to provide support to meet individualised needs. Understanding and putting yourself in the shoes of the patient and how they feel. Not distancing yourself from the patient. Personal prejudices. Impact of cultural background of the nurse and patient. Altruism. Reciprocity.	Graber and Mitcham 2004; Sumner 2006, 2008b; Sumner and Fisher 2008; Dewar and Mackay 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Burnell and Agan 2013; Crawford et al. 2013; Fry et al. 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Richardson, Percy and Hughes 2015; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c, 2016d, 2018; Strauss et al. 2016; Durkin, Gurbutt and Carson 2018; Singh et al. 2018; Babaei and Taleghani's 2019
Overarching Theme – Organisational issues	
Sub themes – Organisational culture; The influence of managers and leaders; The workplace environment; Measuring compassionate care; Compassion Fatigue; Self-compassion.	
Organisational culture	
Negative impact of organisational culture. System constraints. Focus on efficiency, financial savings, meeting targets. Shared values, assumptions, and beliefs. Impact of culture on patient outcomes.	Horsburgh and Ross 2013; Bramley and Matiti 2014; Dixon-Woods *et al*. 2014; Christiansen *et al*. 2015; de Zulueta 2016; Jones *et al*. 2016; Sinclair et al. 2016b, Braithwaite et al. 2017; Mac Arthur et al. 2017; Singh et al. 2018; Babaei and Taleghani 2019.

The influence of managers, leaders, and mentors.	
Senior managers need to visibly reflect core organisational values. Visible role models, and supportive, collaborative teams. Mentorship and role models. Positive action can engender higher levels of compassion satisfaction and lower levels of burnout. Developing compassionate leadership. Leadership training.	Adamson and Dewar 2011; Dewar *et al.* 2010; Crawford et al. 2013; Curtis 2013; Dewar and Nolan 2013; Fry et al. 2013; Horsburgh and Ross 2013; Bray et al. 2014; Christiansen *et al*. 2015; Dewar and Cook 2014; Dixon-Woods *et al.* 2014; Hunsaker et al. 2015; Jones *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b; MacArthur et al. 2017; Singh et al. 2018; Babaei and Taleghani 2019.
The workplace environment	
Workload issues, lack of time, and staff. Increased paperwork with a focus on metrics and efficiency. Focus on routines instead of patients. Dissonance between professional ideals and practice reality.	Curtis, Horton and Smith 2012; Crawford et al. 2013; Curtis 2013; Fry et al. 2013; Bray et al. 2014; Bray et al. 2014; Christiansen *et al*. 2015; Jones *et al*. 2016; Sinclair et al. 2016b; Singh et al. 2018; MacArthur et al. 2017; Babaei and Taleghani 2019.
Measuring compassionate care	
Interventions to achieve compassionate care and their evaluation. Reliability and validity of measures.	Burnell and Agan 2013; Dewar and Nolan 2013; Dewar and Cook 2014; Blomberg *et al*. 2016; Strauss et al. 2016; Sinclair *et al*. 2017a; Durkin, Gurbutt and Carson 2018
Compassion satisfaction and compassion fatigue	
Increased job satisfaction. Nurses internal motivation. Impact of stress on physical, emotional, social, and spiritual health of healthcare providers. Emotional regulation. Compassion fatigue. Self-care strategies.	Graber and Mitcham 2004; Perry 2009; Burtson and Stichler 2010; van der Cingel 2011; Way and Tracy 2012; Fry et al. 2013; Hunsaker et al. 2015; Sinclair et al. 2017b, 2017c.
Overarching Theme – Educational issues	
Sub themes – Learning in practice and university; Challenges to nurse teachers; Teaching compassion.	
Learning in practice and university	
Time constraints limit mentoring, group, or self-reflective opportunities within the practice area. Nurses do not feel prepared to provide compassionate care from their educational experience. University placing increased value on corporate goals related to research output, recruitment, retention, and student satisfaction.	Curtis 2013; Horsburgh and Ross 2013; Bray et al. 2014; Smith et al., 2014; Papadopoulos et al. 2016b; Sinclair et al. 2016a, 2016b; Babaei and Taleghani 2019;
Challenges to nurse teachers	
Managing large student groups. Teaching environment. Emphasis on knowledge-based competencies	Curtis 2013; Horsburgh and Ross 2013; Bray et al. 2014; Smith et al. 2014; Adamson and Dewar 2015.
Teaching compassion	
Can compassion be nurtured, gained through experience, or is simply an innate quality.	Dewar and Mackay 2010; van der Cingel 2011; Dewar and Nolan 2013; Horsburgh and Ross

Developing skills in relationship building. Developing educational interventions to cultivate compassion. Building on existing skills. Experiential learning. Reflective learning. Compassion scale could contribute to recruitment process and ongoing development of compassion.	2013; Bramley and Matiti 2014; Smith et al., 2014; Adamson and Dewar 2015; Kneafsey et al. 2015; Richardson, Percy and Hughes 2015; Blomberg *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair *et al*. 2016a, 2016b, 2018; Durkin, Gurbutt and Carson 2018.

Appendix 6 – Constant Comparative Analysis – theme and sub theme development related to the MCCNCAT (Sumner 2008a)

UNIVERSAL CORE: NEED FOR "CONSIDERATENESS" (Moral Construct of Caring in Nursing as Communicative Action Theory) (MCCNCAT) (Sumner 2008a)
Outcomes **Satisfaction** **Validation** **<physis>** **Blossoming, Thriving (Need for "Considerateness" for each met).**
Overarching Theme – Personal/relational issues – Nurse as Personal Self
Sub themes – Interpersonal factors; Communication; Relational factors; Compassion satisfaction and compassion fatigue
Innate Characteristics; Understanding of Self
Personal values and beliefs. Impact of family upbringing. Personal experiences of suffering. Understanding and vulnerability derived from experience assisted provision of compassion. Motivation.
Communication
Good communication skills. Personal attributes and behaviours. Verbal and nonverbal communication Communication and collaboration among different professions
Relational factors – **Nurse as Personal Self and Patient as Illness Self**
Connecting to the unique needs and experiences of the patients and their suffering. Demonstrating respect, willingness to provide support to meet individualised needs. Understanding and putting yourself in the shoes of the patient and how they feel. Not distancing yourself from the patient. Personal prejudices. Impact of cultural background of the nurse and patient
Overarching Theme – Organisational issues – Environment impacts on Nurse as Personal Self and Patient as Illness Self
Sub themes – Organisational culture; The influence of managers and leaders; The workplace environment; Measuring compassionate care
Organisational culture
Negative impact of organisational culture. System constraints. Focus on efficiency, financial savings, meeting targets. Shared values, assumptions, and beliefs. Impact of culture on patient outcomes.
The influence of managers, leaders, and mentors.
Senior managers need to visibly reflect core organisational values. Visible role models, and supportive, collaborative teams. Mentorship and role models. Positive action can engender higher levels of compassion satisfaction and lower levels of burnout. Developing compassionate leadership. Leadership training.
The workplace environment

Workload issues, lack of time, and staff. Increased paperwork with a focus on metrics and efficiency. Focus on routines instead of patients. Dissonance between professional ideals and practice reality.
Measuring compassionate care
Interventions to achieve compassionate care and their evaluation. Reliability and validity of measures.
Compassion satisfaction and compassion fatigue
Increased job satisfaction. Nurses internal motivation. Impact of stress on physical, emotional, social, and spiritual health of healthcare providers. Emotional regulation. Compassion fatigue. Self-care strategies.
Overarching Theme – Educational issues – Nurse as Professional Self
Sub themes – Learning in practice and university; Challenges to nurse teachers; Teaching compassion.
Learning in practice and university
Dissonance between professional ideals and practice reality. Time constraints limit mentoring, group, or self-reflective opportunities within the practice area. Nurses' do not feel prepared to provide compassionate care from their educational experience. University placing increased value on corporate goals related to research output, recruitment, retention, and student satisfaction.
Challenges to nurse teachers
Managing large student groups. Teaching environment. Emphasis on knowledge-based competencies
Teaching compassion
Can compassion be nurtured, gained through experience, or is simply an innate quality. Developing skills in relationship building. Developing educational interventions to cultivate compassion. Building on existing skills. Experiential learning. Reflective learning. Compassion scale could contribute to recruitment process and ongoing development of compassion.

Appendix 7 – Reduction of statements during the Q set development

Examples of statements developed from the concourse.	Evidence of reduction or re-phrasing of statements due to duplication and lack of clarity.
• I must pay attention to the emotions of others and read subtle cues in my interactions with them. • I must recognise the meanings of communication behaviours as well as the meanings of what is not being communicated. • I must be aware that the most effective communication is conveyed non-verbally. • I must respond to the patient through non-verbal ques as these are more effective than verbal.	• More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say.
• I must understand and relate to the patient's socio-economic circumstances and ethnic background. • I must realise different cultures and genders express themselves differently. • I must delegate to others when the patient is difficult to understand.	• I find it easier to provide compassionate care when I share the same background or culture with the patient.
• I must have good role models in practice. • Managers must be role models in caregiving. • I must have a mentor/more experienced member of staff as a sounding board to discuss poor practice. • I must have continuity/a continuous working relationship with a role model in practice to guide me. • I must accept that I will work with poor role models that provide haphazard instruction and demonstrate unethical behaviour.	• Managers must be visible role models showing compassion. • Regardless of the knowledge and skills of the mentor I can still maintain high standards of care. • My manager/mentor supports me to learn from examples of excellent care.
• I must accept that with limited time and many patients I cannot provide the quality of care I want to. • I must complete tasks quickly.	• The more time I spend with one patient, the poorer the care another receives.

• I must accept that increased responsibilities in practice mean patient care is compromised.	
• I must be allowed to express my emotions in practice. • I must be able to share feelings openly. • I must manage my own emotions to act in the best interest of the patient.	• It is unprofessional to show my personal emotions about a patient. • It helps me to give good care when I say what I am feeling to the patients. • Colleagues don't like it when I express my feelings at work.

Appendix 8 – Final Q set, with themes and references that influenced their development

Q statements	Overarching themes			Associated references from literature that influenced the development of the statement.
	Personal Relational issues	Organisational issues	Educational issues	
1. More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say.	✓		✓	Sumner 2006, 2008b; Schantz 2007; Sumner and Fisher 2008; Burnell 2009; Perry 2009; Dewar and Mackay 2010; Dewar et al. 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Crawford et al. 2013; Dewar and Nolan 2013; Horsburgh and Ross 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Kneafsey et al. 2015; Jones *et al*. 2016; Papadopoulos et al. 2016b; Sinclair et al. 2016b, 2016c, 2016d,
2. Professional development is important in improving standards of practice.	✓	✓	✓	Adamson and Dewar 2015; Dewar and Mackay 2010; Dewar *et al*. 2010; Edinburgh Napier University and NHS Lothian 2012; Horsburgh and Ross 2013; Sinclair *et al*. 2016c, 2016d,
3. It is harder to provide compassionate care when my values conflict with the organisational values.	✓		✓	Graber and Mitcham 2004; Sumner 2006, 2008b; Sumner and Fisher 2008; Van der Cingel 2011; Badger and Royse 2012; Way and Tracy 2012; Burnell and Agan 2013; Dewar and Nolan 2013; Adamson and Dewar 2015;Christiansen *et al*. 2015; Kneafsey et al. 2015; Jones *et al*. 2016; Sinclair et al. 2016b, 2016d.
4. It is unprofessional to show my personal emotions about a patient.	✓	✓	✓	Sumner 2006, 2008b; Van der Cingel 2011; Curtis 2013; Curtis, Horton and Smith 2012; Jones et al. 2015.

5. It is OK for things affecting my personal life to influence the care I provide.	✓	✓	✓	Sumner 2006; Christiansen *et al*. 2015; Jones et al. 2016; Sinclair 2016b. 2016c
6. I am much more likely to be short tempered with a patient when I am being unfairly treated.	✓	✓	✓	Sumner 2008b; Christiansen *et al*. 2015; Jones et al. 2016.
7. It's OK to use humour with patients.	✓		✓	Dewar and Nolan 2013; Burnell and Agan 2013 Also referred to own experiences in practice.
8. It helps me to give good care when I say what I am feeling to the patients.	✓		✓	Graber and Mitcham 2004; Sumner 2006, 2008b; Sumner and Fisher 2008; Dewar and Mackay 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Burnell and Agan 2013; Crawford et al. 2013; Fry et al. 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Richardson, Percy and Hughes 2015; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c, 2016d; Strauss et al. 2016;
9. Colleagues don't like it when I express my feelings at work.	✓	✓	✓	Curtis, Horton and Smith 2012; Horsburgh and Ross 2013; Bramley and Matiti 2014
10. It's easier to provide compassionate care when I like the patient.	✓		✓	Graber and Mitcham 2004; Sumner 2006; Christiansen *et al*. 2015; De Zulueta 2016; Jones et al. 2016
11. Teaching in the university creates unrealistic expectations of compassion that I cannot achieve.	✓	✓	✓	Dewar and Mackay 2010; Curtis 2013; Horsburgh and Ross 2013; Bramley and Matiti 2014; Bray et al. 2014; Smith et al. 2014; Blomberg et al. 2016; Sinclair et al. 2016d.
12. The more time I spend with one patient, the poorer the care another receives.	✓	✓	✓	Curtis, Horton and Smith 2012; Badger and Royse 2012; Crawford et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; De Zulueta 2016; Jones *et al*. 2016.

13. Managers must be visible role models showing compassion.		✓	✓	Dewar *et al.* 2010; Adamson and Dewar 2011; Badger and Royse 2012; Crawford et al. 2013; Curtis 2013; Dewar and Nolan 2013; Fry et al. 2013; Horsburgh and Ross 2013; Bray et al. 2014; Christiansen *et al*. 2015; Dewar and Cook 2014; Dixon-Woods *et al.* 2014; Hunsaker et al. 2015; de Zulueta 2016; Jones *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b
14. Regardless of the knowledge and skills of the mentor I can still maintain high standards of care.		✓	✓	Curtis 2013; Dewar and Nolan 2013; Bray et al. 2014; Christiansen et al. 2015; Jones et al. 2016; Sinclair et al. 2016c, 2016d
15. Undercurrents in my workplace influence the care I provide.	✓	✓	✓	Curtis, Horton and Smith 2012; Crawford et al. 2013; Curtis 2013; Fry et al. 2013; Horsburgh and Ross 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen et al. 2015; Dixon-Woods et al. 2015; De Zulueta 2016; Jones et al. 2016.
16. If we can measure compassionate care we are more likely to achieve it.		✓		Burnell and Agan 2013; Dewar and Nolan 2013; Dewar and Cook 2014; Blomberg *et al*. 2016; De Zulueta 2016; Strauss et al. 2016
17. I prefer to focus on physical aspects of care.	✓	✓	✓	Sumner 2006; Badger and Royse 2012; Kvangarsnes et al.2013; Christiansen *et al*. 2015 Jones *et al*. 2016.
18. It is frustrating when my hard work is not appreciated by patients.	✓	✓	✓	Sumner 2006; Curtis, Horton and Smith 2012; Way and Tracy 2012; Christiansen *et al*. 2015; De Zulueta 2016; Jones et al. 2016
19. I find it easier to provide compassionate care when I share the same background or culture with the patient.	✓		✓	Dewar et al. 2010; Christiansen *et al*. 2015; Jones et al. 2015; Papadopoulos et al. 2016a, 2016b.
20. The longer I work in practice the less able I am to provide compassionate care.	✓	✓		Sumner 2006; Hunsaker et al. 2015; Sinclair et al. 2016c, 2016d.
21. When work is busy standards of care are inevitably lower.		✓	✓	Badger and Royse 2012; Crawford et al. 2013; Horsburgh and Ross 2013; Bramley and Matiti 2014; Dixon-Woods *et al*. 2014; Christiansen *et al*.

				2015; de Zulueta 2016; Jones *et al*. 2016; Sinclair et al. 2016b
22. Good physical care is more important than compassion.	✓	✓		Graber and Mitcham 2004; Sumner 2006, 2008b; Sumner and Fisher 2008; Dewar and Mackay 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Burnell and Agan 2013; Crawford et al. 2013; Fry et al. 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Richardson, Percy and Hughes 2015; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c, 2016d
23. To protect myself from undue stress it is important I distance myself from the patient.	✓	✓		Graber and Mitcham 2004; Sumner 2006, 2008b; Schantz 2007; Sumner and Fisher 2008; Dewar and Mackay 2010; van der Cingel 2011; Badger and Royse 2012; Curtis, Horton and Smith 2012; Way and Tracy 2012; Burnell and Agan 2013; Crawford et al. 2013; Fry et al. 2013; Kvangarsnes et al. 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen *et al*. 2015; Richardson, Percy and Hughes 2015; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c, 2016d
24. When a patients' lifestyle has resulted in their condition it is difficult to be as caring.	✓	✓		van der Cingel 2011; Christiansen *et al*. 2015; Jones et al. 2016; Sinclair et al. 2016c.
25. My own life experiences of distress mean I care more effectively for the patient.	✓		✓	Sumner 2006, 2008b; Van der Cingel 2011; Christiansen *et al*. 2015; Jones *et al*. 2016; Sinclair et al. 2016c, 2016d
26. Compassionate care is not critical to safe care.		✓		van der Cingel 2011; Badger and Royse 2012; Dixon-Woods et al. 2015.
27. Organisational targets get in the way of compassionate care.	✓	✓		Crawford et al. 2013; Curtis 2013; Fry et al. 2013; Bray et al. 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; de Zulueta 2016; Jones *et al*. 2016; Sinclair et al. 2016b, 2016c.

28. If staff are kind to each other then compassionate patient care is more likely.	✓	✓		Sumner 2006; Curtis, Horton and Smith 2012; Fry et al. 2013; Horsburgh and Ross 2013; Bramley and Matiti 2014; Bray et al. 2014; Christiansen et al. 2015; Hunsaker et al. 2015; De Zulueta 2016; Jones et al. 2016
29. I am influenced by the values and behaviours of the team I work with.	✓	✓		Badger and Royse 2012; Curtis, Horton and Smith 2012; Horsburgh and Ross 2013; Kvangarsnes *et al*. 2013; Bramley and Matiti 2014; Adamson and Dewar 2015; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; Hunsaker et al. 2015; Richardson, Percy and Hughes 2015; Sinclair 2016c, 2016d.
30. My manager/mentor supports me to learn from examples of excellent care.		✓	✓	Dewar and Mackay 2010; Adamson and Dewar 2011; Curtis 2013; Dewar and Nolan 2013; Fry et al. 2013; Horsburgh and Ross 2013; Dewar and Cook 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; Hunsaker et al. 2015; de Zulueta 2016; Jones et al. 2016; Papadopoulos *et al*. 2016a, 2016b; Sinclair et al. 2016d.
31. When I feel taken for granted by my manager its harder for me to give compassionate care.	✓	✓		Adamson and Dewar 2011; Dewar *et al.* 2010; Crawford et al. 2013; Curtis 2013; Dewar and Nolan 2013; Fry et al. 2013; Horsburgh and Ross 2013; Bray et al. 2014; Christiansen *et al*. 2015; Dewar and Cook 2014; Dixon-Woods *et al.* 2014; Hunsaker et al. 2015; De Zulueta 2016; Jones *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c.
32. Self-disclosure helps me build rapport with the patient.	✓	✓	✓	Sumner 2006; Perry 2009; van der Cingel 2011; Christiansen *et al*. 2015; Richardson, Percy and Hughes 2015; Sinclair et al. 2016d.
33. The more knowledgeable I am the more compassionate I become.	✓		✓	Burnell 2009; Curtis, Horton and Smith 2012; Curtis 2013; Dewar and Nolan 2013; Bray et al.

				2014; Christiansen et al. 2015; Jones et al. 2016; Sinclair et al. 2016b, 2016d.
34. Compassion cannot be taught it is something that you have.	✓		✓	Dewar and Mackay 2010; Dewar *et al*. 2010; van der Cingel 2011; Curtis, Horton and Smith 2012;; Dewar and Nolan 2013; Horsburgh and Ross 2013; Bramley and Matiti 2014; Smith et al., 2014; Adamson and Dewar 2015; Kneafsey et al. 2015; Richardson, Percy and Hughes 2015; Blomberg *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair *et al*. 2016a, 2016b.
35. Managerial values focusing on safety and targets are incompatible to achieving compassionate care.		✓		Crawford et al. 2013; Fry et al. 2013; Bray et al. 2014; Bray et al. 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; de Zulueta 2016; Jones *et al*. 2016; Sinclair et al. 2016d.
36. Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.	✓	✓	✓	Dixon-Woods et al. 2015; Jones et al. 2015; De Zulueta 2016; Papadopoulos et al. 2016a; Sinclair et al. 2016b.
37. Feedback from colleagues helps me to overcome any negative attitudes I may have.	✓	✓	✓	Adamson and Dewar 2011; Dewar *et al.* 2010; Bramley and Matiti 2014; Bray et al. 2014; Dewar and Cook 2014.
38. If I am told a relative is likely to complain I can make more effort to prevent this.	✓		✓	Developed following feedback from pilot stage of research. Christiansen *et al*. 2015; Jones et al. 2016.
39. My own personal safety is my main priority.	✓	✓	✓	Sumner 2006; van der Cingel 2011; Badger and Royse 2012; Hunsaker et al. 2015.
40. Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives.	✓	✓	✓	Dewar and Cook 2014; Dixon-Woods et al. 2015; de Zulueta 2016; Papadopoulos *et al*. 2016a, 2016b.
41. Relatives are reluctant to complain as they believe this will impact on the care the patient receives.	✓	✓		Developed following feedback from pilot stage of research. Christiansen *et al*. 2015; Jones et al. 2016

42. Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance.	✓	✓		Developed following feedback from pilot stage of research. Christiansen et al. 2015;
43. The organisational culture which I work within builds trust and honesty.	✓	✓		Bramley and Matiti 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; de Zulueta 2016; Jones *et al*. 2016; Papadopoulos *et al*. 2016a, 2016b.
44. Demonstrating compassionate behaviours influences patient outcomes positively.	✓	✓	✓	Graber and Mitcham 2004; Van der Cingel 2011; Dewar and Cook 2014; Dixon-Woods et al. 2015; Jones et al. 2015; De Zulueta 2016; Papadopoulos *et al*. 2016a, 2016b.
45. Ward leadership has enormous impact on the quality of compassionate care provided by team members.	✓	✓	✓	Dewar and Mackay 2010; Dewar and Nolan 2013; Horsburgh and Ross 2013; Bray et al. 2014; Dewar and Cook 2014; Dixon-Woods et al. 2015; Jones et al. 2015; de Zulueta 2016; Papadopoulos *et al*. 2016a, 2016b
46. Teams within wards that feel less supported by their manager provide poorer compassionate care.	✓	✓	✓	Dewar and Mackay 2010; Curtis 2013; Dewar and Nolan 2013; Fry et al. 2013; Horsburgh and Ross 2013; Dewar and Cook 2014; Christiansen *et al*. 2015; Dixon-Woods et al. 2015; Hunsaker et al. 2015; de Zulueta 2016; Papadopoulos *et al*. 2016a, 2016b; Sinclair et al. 2016d.
47. Opportunities to discuss issues in practice are regularly available.	✓	✓	✓	Dewar and Mackay 2010; Adamson and Dewar 2011; van der Cingel 2011; Curtis 2013; Bramley and Matiti 2014; Dewar and Nolan 2013; Dewar and Cook 2014; Blomberg et al. 2016; Dixon-Woods et al. 2015; de Zulueta 2016; Sinclair et al. 2016c.
48. Recruitment of already compassionate individuals to nursing ensures compassionate care.	✓	✓	✓	Bray et al. 2014; Bramley and Matiti 2014; Kneafsey et al. 2015; Papadopoulos et al. 2016a, 2016b; Sinclair et al. 2016b, 2016c, 2016d;
49. In the practice area team members have clear roles and responsibilities.	✓	✓		Christiansen *et al*. 2015; Dixon-Woods et al. 2015; De Zulueta 2016; Sinclair et al. 2016b.

50. The nursing course does not prepare you to face the long term emotional demands of practice.	✓	✓	✓	van der Cingel 2011; Curtis, Horton and Smith 2012; Curtis 2013; Dewar and Nolan 2013; Horsburgh and Ross 2013; Bray et al. 2014; Papadopoulos *et al.* 2016a, 2016b; Sinclair et al. 2016c, 2016d
Feedback from the focus groups suggested adding four further statements.				
51. Compassion isn't limitless and sometimes I have given all I can.	✓	✓		Developed following feedback from pilot stage of research. Burtson and Stichler 2010; Way and Tracy 2012; Fry et al. 2013; Hunsaker et al. 2015; De Zulueta 2016; Sinclair et al. 2016b.
52. The way relatives treat me has influenced my understanding of compassionate care.	✓		✓	Developed following feedback from pilot stage of research. Dewar *et al*. 2010; Dewar and Nolan 2013; Christiansen et al. 2015; Jones et al. 2015
53. I feel equipped to deal with patients' suffering.	✓		✓	van der Cingel; Curtis, Horton and Smith 2012; Curtis 2013; Dewar and Nolan 2013; Horsburgh and Ross 2013; Bray et al. 2014; Dewar and Cook 2014; Papadopoulos *et al.* 2016a, 2016b; Sinclair et al. 2016c, 2016d
54. Education has equipped me to challenge uncompassionate practice.	✓		✓	van der Cingel 2011; Dewar and Nolan 2013; Bray et al. 2014; Bramley and Matiti 2014; Dewar and Cook 2014; Smith et al., 2014; Adamson and Dewar 2015; Kneafsey et al. 2015; Richardson, Percy and Hughes 2015; Blomberg *et al*. 2016; Papadopoulos et al. 2016a, 2016b; Sinclair *et al*. 2016a, 2016b

Appendix 9 – Final Q statements within overarching themes.

Personal/relational Involved 18 clusters of variables that contributed to three subthemes: Interpersonal factors; Communication; and Relational factors.	**Organisational** Involved 23 clusters of variables that contributed to five sub themes: The Organisational culture; The influence of managers, leaders, and mentors; The workplace environment; Measuring compassionate care; and Compassion satisfaction and compassion fatigue.
1. More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say. 4. It is unprofessional to show my personal emotions about a patient. 5. It is OK for things affecting my personal life to influence the care I provide. 6. I am much more likely to be short tempered with a patient when I am being unfairly treated. 7. It's OK to use humour with patients. 8. It helps me to give good care when I say what I am feeling to the patients. 10. It's easier to provide compassionate care when I like the patient. 17. I prefer to focus on physical aspects of care. 18. It is frustrating when my hard work is not appreciated by patients. 19. I find it easier to provide compassionate care when I share the same background or culture with the patient. 22. Good physical care is more important than compassion. 23. To protect myself from undue stress it is important I distance myself from the patient. 24. When a patients' lifestyle has resulted in their condition it is difficult to be as caring. 25. My own life experiences of distress mean I care more effectively for the patient. 32. Self-disclosure helps me build rapport with the patient.	3. It is harder to provide compassionate care when my values conflict with the organisational values. 9. Colleagues don't like it when I express my feelings at work. 12. The more time I spend with one patient, the poorer the care another receives. 13. Managers must be visible role models showing compassion. 15. Undercurrents in my workplace influence the care I provide. 20. The longer I work in practice the less able I am to provide compassionate care. 21. When work is busy standards of care are inevitably lower. 16. If we can measure compassionate care we are more likely to achieve it. 26. Compassionate care is not critical to safe care. 27. Organisational targets get in the way of compassionate care. 28. If staff are kind to each other then compassionate patient care is more likely. 29. I am influenced by the values and behaviours of the team I work with. 30. My manager/mentor supports me to learn from examples of excellent care. 31. When I feel taken for granted by my manager its harder for me to give compassionate care. 35. Managerial values focusing on safety and targets are incompatible to achieving compassionate care. 36. Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.

38. If I am told a relative is likely to complain I can make more effort to prevent this. 39. My own personal safety is my main priority. 41. Relatives are reluctant to complain as they believe this will impact on the care the patient receives. 42. Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance. 52. The way relatives treat me has influenced my understanding of compassionate care. **20 statements**	40. Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives. 43. The organisational culture which I work within builds trust and honesty. 44. Demonstrating compassionate behaviours influences patient outcomes positively. 45. Ward leadership has enormous impact on the quality of compassionate care provided by team members. 46. Teams within wards that feel less supported by their manager provide poorer compassionate care. 47. Opportunities to discuss issues in practice are regularly available. 49. In the practice area team members have clear roles and responsibilities. 51. Compassion isn't limitless and sometimes I have given all I can. **24 statements**
Education Involved 13 clusters of variables that contributed to three subthemes: Learning in practice and university; Challenges to nurse teachers; and Teaching compassion.	
2. Professional development is important in improving standards of practice. 11. Teaching in the university creates unrealistic expectations of compassion that I cannot achieve. 14. Regardless of the knowledge and skills of the mentor I can still maintain high standards of care. 33. The more knowledgeable I am the more compassionate I become. 34. Compassion cannot be taught it is something that you have. 37. Feedback from colleagues helps me to overcome any negative attitudes I may have. 48. Recruitment of already compassionate individuals to nursing ensures compassionate care. 50. The nursing course does not prepare you to face the long term emotional demands of practice. 53. I feel equipped to deal with patients' suffering. 54. Education has equipped me to challenge uncompassionate practice. **10 statements**	

Appendix 10 – Report sheet

REPORT SHEET – to be completed following the Q-sort

Nurses' views on compassionate care: a study using Q methodology
(Participant reference number ……..)

Your contribution has been really valuable and to just complete the process could you please write your reasons for placing cards in the extreme destination columns e.g. Most Agree (+5 and +4 cards) and Most Disagree (-5 and -4 cards).

Most Agree statements	**Your reasons explaining why you placed cards in the extreme destination columns**
+5	
+5	
+4	
+4	
+4	
+4	

Most Disagree statements	Your reasons explaining why you placed cards in the extreme destination columns
-5	
-5	
-4	
-4	
-4	
-4	

As you reflect on your responses to the 'card sort' it would be really helpful if you could identify how you believe nurses maintain compassionate care…….

I sincerely thank you for your responses.

Appendix 11 – University of Wolverhampton ethical panel decision letters

Date 29th May 2015

University of Wolverhampton
FEHW

Dear Ann Philp (Supervisor Neil Duncan)

Re: Nurses' views on compassionate care: a Q method study
submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission.

On review your Research Proposal was passed and given approval **Code 2 – Approved Subject to Conditions.** The conditions for Approval are below.

A. Researcher/Supervisor to Monitor. Please address the minor amendments detailed below. If this is student research, supervisors must ensure the minor amendments have been completed prior to commencement of data collection. A condition of this approval is that Supervisors must read through and check the revised applications and email a confirmation to fehwethics@wlv.ac.uk to confirm they have occurred.

Required changes

- It is possible that the group discussion could give rise to safeguarding concerns that patients are or have been placed at risk on account of poor nursing practices. This needs to be acknowledged and you need to be explicit about how you would address this issue. This also links to the need to advise participants about the limits of confidentiality and also there is a need to mention this in the participant information sheet.
- It is stated in several places that participants will be informed of their right to withdraw from the study at any time. This needs to be reworded to: up until the data is analysed. This consequently needs to be amended in the participant information sheet and consent form so that people are aware if this limitation.
- The proposal needs more description of the participants and recruitment process

Suggested changes

- Statement about withdrawal is included twice. The time limit for withdrawal needs to be specified.
- The invitation letter needs to be revised in accordance with the participant information sheet proforma (ie with some sub headings) to make it more user friendly. There is a need to provide additional information about

1

dissemination of findings and information about who individuals can contact if they have an issue (this is currently in the consent form and would be better placed in the information sheet.)

- The vignette mentions that the patient is on a surgical ward, it may be worth considering not mentioning what ward the patients are on to make the vignette appropriate to all participating nurses (mental health, learning disability, children, adult).
- Consider the inclusion of an escalation policy for the researcher should any professional issues arise that would alert the researcher to a participant implying that a lack of compassion is acceptable or perhaps divulging experience of or witnessing poor care relating to compassion within their own practice setting by another colleague.

Best wishes in the future.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE., CPSYCHOL.
Chair – Ethics Panel

17th August 2016

Ann Philp
University of Wolverhampton
FEHW

Dear Ann Philp (Robin Gutteridge)

Re: Nurses' views on compassionate care: a Q method study
Submitted to the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

Thank you for notifying us of your recent amendment to your proposal.

We do not have any ethical concerns with the changes and will keep these on your student file.

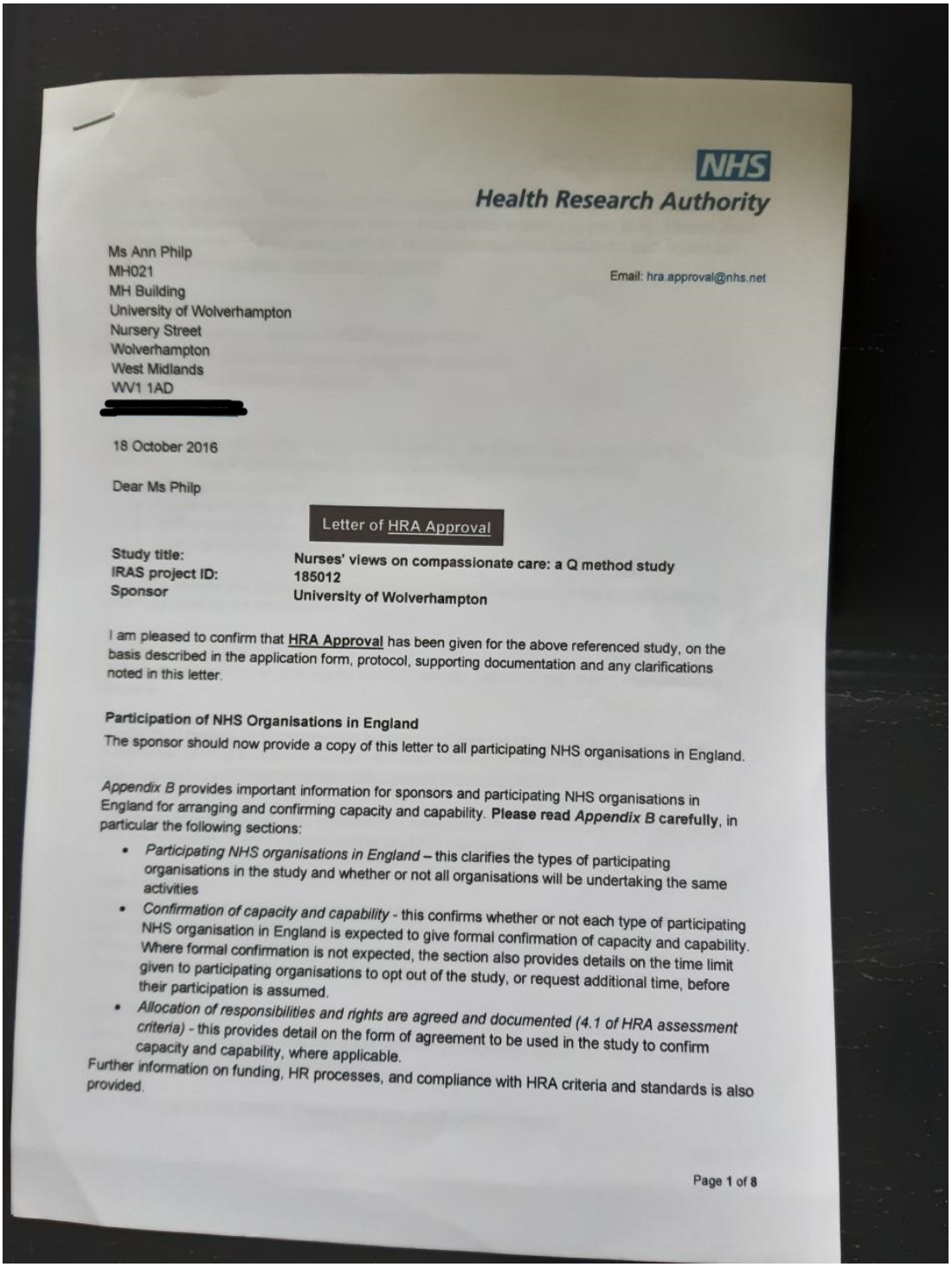
We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee

Richard Darby
Dr Richard Darby PhD, BSc
Chair – Ethics Panel

Appendix 12 – The Integrated Research Application System (IRAS) (project185012) and Health Research Authority (HRA) ethics approval



NHS
Health Research Authority

Ms Ann Philp
MH021
MH Building
University of Wolverhampton
Nursery Street
Wolverhampton
West Midlands
WV1 1AD
[redacted]

Email: hra.approval@nhs.net

18 October 2016

Dear Ms Philp

Letter of HRA Approval

Study title:	**Nurses' views on compassionate care: a Q method study**
IRAS project ID:	**185012**
Sponsor	**University of Wolverhampton**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

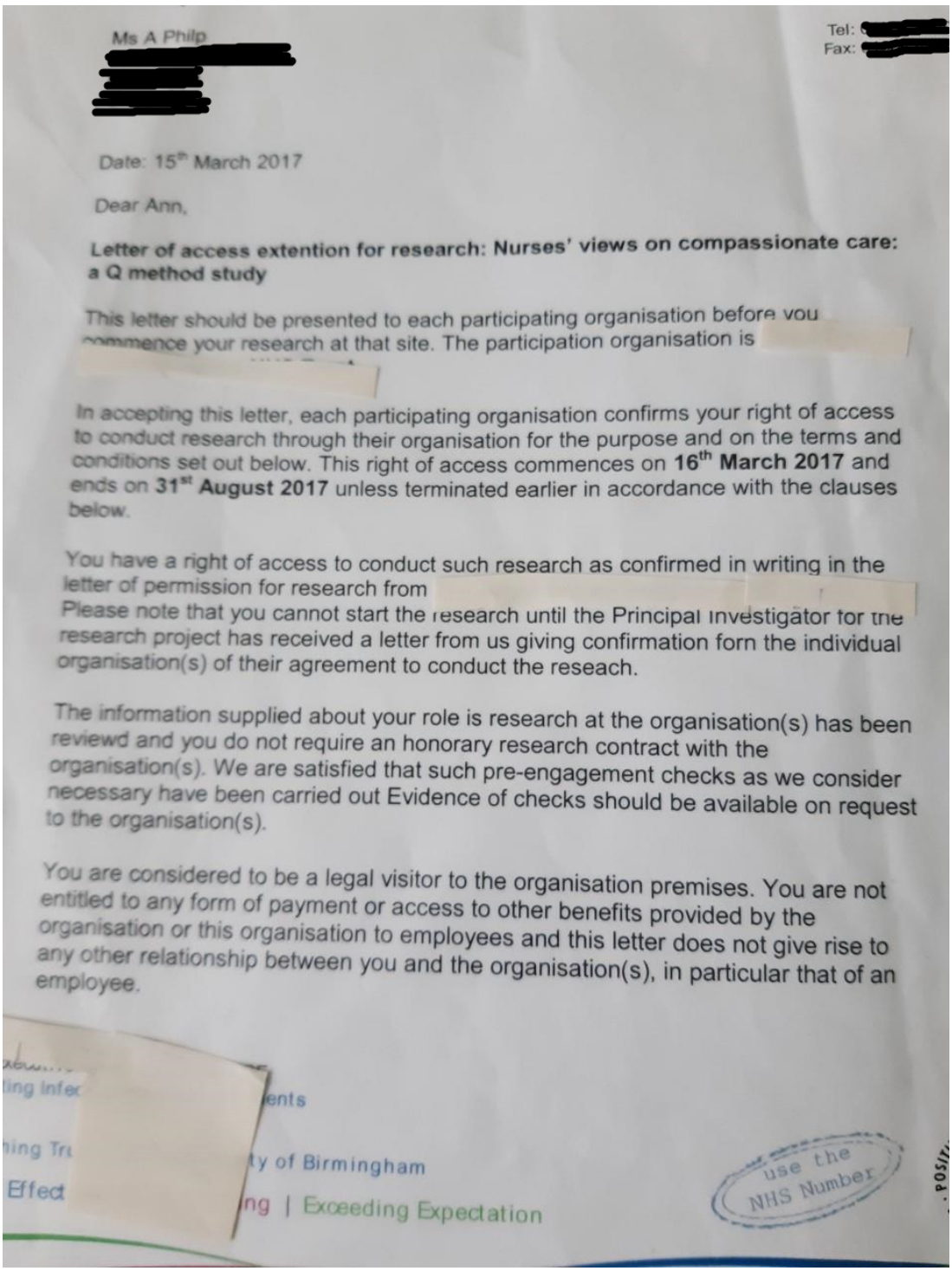
Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page 1 of 8

Appendix 13 – Anonymised Trust hospital approval letter



Ms A Philp
[redacted]

Tel: [redacted]
Fax: [redacted]

Date: 15th March 2017

Dear Ann,

Letter of access extention for research: Nurses' views on compassionate care: a Q method study

This letter should be presented to each participating organisation before you commence your research at that site. The participation organisation is [redacted]

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **16th March 2017** and ends on **31st August 2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from [redacted]
Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation forn the individual organisation(s) of their agreement to conduct the reseach.

The information supplied about your role is research at the organisation(s) has been reviewd and you do not require an honorary research contract with the organisation(s). We are satisfied that such pre-engagement checks as we consider necessary have been carried out Evidence of checks should be available on request to the organisation(s).

You are considered to be a legal visitor to the organisation premises. You are not entitled to any form of payment or access to other benefits provided by the organisation or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation(s), in particular that of an employee.

[redacted]

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Appendix 14 – Participant letter of invite

Dear colleague,

I am writing to invite you as [appropriate term inserted - a third year student nurse / adult registered nurse] to participate in a research project entitled ***Nurses' views on compassionate care: a study using Q methodology.***

There is an increasing emphasis on the importance of caring in health care and it is important that research is conducted into what it means to nurses to be compassionate and how they can be supported to achieve compassionate care. The purpose of this research therefore is to explore the views of both student nurses and qualified adult nurses on compassionate care.

The benefits of this research will be to provide new and unique insights into the attitudes and viewpoints of nurses with regards to the provision and maintenance of compassionate practice. It is anticipated that the results will contribute to the educational and practice preparation of nurses to provide and maintain compassionate care; the cultural socialization of nurses through education and practice; and how they can be supported to achieve compassionate care.

I have also enclosed an Information Sheet providing further detail of the structure of the research project. It will require a maximum of 60 minutes of your time and the meeting would be arranged at either the University of Wolverhampton or *(trust name anonymised)*. **Following your participation, I would provide a certificate and written testimony identifying your involvement in this project which would contribute to your portfolio and revalidation.**

If you are willing to participate in the research, or have any questions before agreeing, please feel free to contact me via email: [e-mail address redacted]. I very much appreciate your support in this.

Thank you,

Ann

Ann Philp

[Mobile number redacted]

Principal Investigator: Ms. Ann Philp, doctoral student undertaking the Professional Doctorate in Health and Wellbeing at the University of Wolverhampton.

Director of Studies: Dr Robin Gutteridge, Reader in Applied Social Psychology and Innovation, Faculty of Education Health and Wellbeing, University of Wolverhampton.

This study has been reviewed and received ethics clearance through the Research Ethics Committee, University of Wolverhampton. IRAS project ID 185012.

Appendix 15 – Participant information sheet

Participant Information Sheet

Title of research project: Nurses' views on compassionate care: a study using Q methodology.

Project aims.

The overall aim of the study is to explore nurses' views on compassionate care.

Participation

The research will involve both student nurses and qualified nurses. The 'card sort' activity involving 3rd year nursing students will take place at the University of Wolverhampton or *(trust name anonymised),* and those for qualified nurses will take place at *(trust name anonymised)*. All participants will either be employed by *(trust name anonymised)* or student nurses will be experiencing their 'hub' practice placements at this Trust.

Structure of the research

The research will involve participants being presented with a selection of statements representative of a range of viewpoints. Participants will be asked to rank order these sets of statements on a pre-prepared grid using a scale ranging from Strongly Agree to Strongly Disagree. Following the sorting of these statements, participants will be asked to complete a Report Sheet to provide insight into their decision making. Overall, participants will be required to attend for approximately 60 minutes and will be audio recorded.

Confidentiality and anonymity

Participation in this research is voluntary and participants are free to withdraw at any time. All data collected will be anonymised and any information used in reporting will not identify participants thus ensuring confidentiality. All data will be stored securely and used according to the requirements of the Data Protection Act (1998).

Overall, this research is seen as low risk to the participants, however, at commencement of the activity ground rules will be discussed identifying that you are guided only to discuss information that you are comfortable with. Anything disclosed will remain confidential unless there is a safeguarding issue or malpractice is identified and then this would be discussed with the participant and how to action the Trust safeguarding procedure/policy.

If you have any questions, please feel free to contact me via email at: [e-mail address redacted]

If you have any concerns regarding this research the Director of Studies is Dr Robin Gutteridge and can be contacted via email at: [e-mail address redacted]

About Q-Methodology

Q-methodology was created by William Stephenson (1935) and is a research technique and associated set of theoretical and methodological concepts which focuses on the subjective or first-person viewpoints of its participants. Subjective viewpoints are analysed using a combination of qualitative and quantitative techniques.

Q-studies begin by capturing the flow of communication about a given topic, referred to as the *concourse* (Simons, 2013; Watts & Stenner, 2012). It requires the production of a vast set of statements that represent as many different viewpoints on a given topic as possible — the 'concourse'. These are drawn from the literature, personal experience, expert opinion, and any other suitable source. A comprehensive literature review has been conducted to include a wide range of sources and from this a draft set of statements has been created (draft Q set). These statements are then to be taken to **Pre-Pilot groups** with a limited number of 'expert' qualified nurses (nurse lecturers within the University of Wolverhampton) and a group of 3rd year student nurses (3-5 individuals). **The aim of this is to help with clarification of the wording of individual items, to reduce duplication, to generate new items and to ensure that the Q set provides adequate coverage of the relevant ground.**

Following the Pre-Pilot stage the researcher will consider feedback from the participants and modify the Q set as necessary. The next stage will be Piloting the Q set, whereby participants 'test' the statements by rank-ordering the statements within the Q set into a forced normal distribution of their levels of agreement or disagreement with each statement (the Q sort). Following completing the sorting of these statements participants will be asked to complete a Report Sheet to provide insight into their decision making. Following the Pilot stage the researcher will consider the results gathered and make any necessary modifications.

Following the Pilot stage the final Q sort is developed and will be presented to the final research participants who will rank-order the statements within the Q set to represent their levels of agreement or disagreement with each statement. Following completing the sorting of these statements participants will be asked to complete a Report Sheet to provide insight into their decision making. The results of the Q sort are then factor-analysed via Q-method software (PQMethod) to render visible factors of items that had statistical significance for the participants. Information from the Report Sheet will be qualitatively analysed.

As a result investigation will take place into the attitudes and viewpoints of nurses with regards to the provision and maintenance of compassionate practice enabling unique insights and potentially recommendations for nursing practice and education.

Terminology

The Concourse – draws information from a range of sources including the literature review; expert opinion; personal opinion; elicitation interviews and any other suitable sources. This will inform the development of the Q set, a list of statements that is representative of the 'universe of viewpoints' about the topic

Q-set – consists of a sample of items to be ranked by the research participants along a continuum (quasi-normal distribution), the poles of which are defined by the researcher in accordance with the demands of the research topic.

Q sort – involves the rank ordering of a set of statements requiring the participant to evaluate (or sort) a number of items along a continuum from, for example, 'strongly agree' to 'strongly disagree'.

Thus the participants give their subjective meaning to statements and by doing so reveal their subjective viewpoints. These viewpoints are then subjected to factor analysis.

References

Simons, J. (2013) An introduction to Q methodology. Nurse Researcher, **20**, 28-32.

Stephenson, W. (1935) Technique of factor analysis. Nature, 136, 297.

Watts, S. & Stenner, P. (2012) Doing Q methodological research: Theory, method and interpretation. London: Sage Publications Inc.

Appendix 16 – Consent form – participant copy

Title of the project: Nurses' views on compassionate care: a study using Q methodology

Consent for Research Participation (Participant Copy – to be signed and kept by participant)

This document invites you to consent to participate in a research study that aims to explore the views of both student nurses and qualified nurses of compassionate practice.

Please place a cross box to confirm:

☐ I am willing to participate in an audio-recorded activity in which I will be able to explore my views of compassionate care.

☐ I have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw without any consequence.

☐ I am satisfied that all data will be stored securely and used according to the requirements of the Data Protection Act (1998).

☐ I understand all data be archived securely at the conclusion of the project and will be destroyed after the required time for secure storage has elapsed.

☐ I understand that data will be anonymised, and any information used in reporting will not identify participants.

☐ I understand the information I provide may be used in the following ways:

- To promote discussion and dialogue in the academic community

- As evidence to help to illuminate how individual practitioners can more effectively collaborate to support compassionate care.

Name of Participant: _____

Signed: _____

Date: _____

Name of witness: _____

Signed: _____

Date: _____

If you require further information about this project, please contact Ann Philp via email [e-mail address redacted]

If you have any concerns about this project, please contact the Director of Studies, Robin Gutteridge via email at [e-mail address redacted]

Appendix 17 – Consent form – file copy

Title of the project: Nurses' views on compassionate care: a study using Q methodology.

Consent for Research Participation (File Copy – to be signed by participant and kept by researcher)

This document invites you to consent to participate in a research study that aims to explore the views of both student nurses and qualified nurses of compassionate practice.

Please place a cross box to confirm:

☐ I am willing to participate in an audio-recorded activity in which I will be able to explore my views of compassionate care.

☐ I have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw without any consequence.

☐ I am satisfied that all data will be stored securely and used according to the requirements of the Data Protection Act (1998).

☐ I understand all data be archived securely at the conclusion of the project and will be destroyed after the required time for secure storage has elapsed.

☐ I understand that data will be anonymised and any information used in reporting will not identify participants.

☐ I understand the information I provide may be used in the following ways:

- To promote discussion and dialogue in the academic community
- As evidence to help to illuminate how individual practitioners can more effectively collaborate to support compassionate care.

Name of Participant: _____

Signed: _____

Date: _____

Name of witness: _____

Signed: _____

Date: _____

If you require further information about this project, please contact Ann Philp via email [e-mail address redacted]

If you have any concerns about this project, please contact the Director of Studies, Robin Gutteridge via email at [e-mail address redacted]

Appendix 18 – Certificate of completion of: Introduction to Good Clinical Practice eLearning (Secondary Care)

NHS
National Institute for Health Research
Clinical Research Network

CERTIFICATE of ACHIEVEMENT

This is to certify that

ANN PHILP

has completed the course

Introduction to Good Clinical Practice eLearning (Secondary Care)

January 6, 2016

Modules completed:

Introduction to Research in the NHS
Good Clinical Practice and Standards in Research
Study Set Up and Responsibilities
The Process of Informed Consent
Data Collection and Documentation
Safety Reporting

This course is worth 4 CPD credits

CPD
The CPD Certification Service

National Institute for Health Research
Clinical Research Network

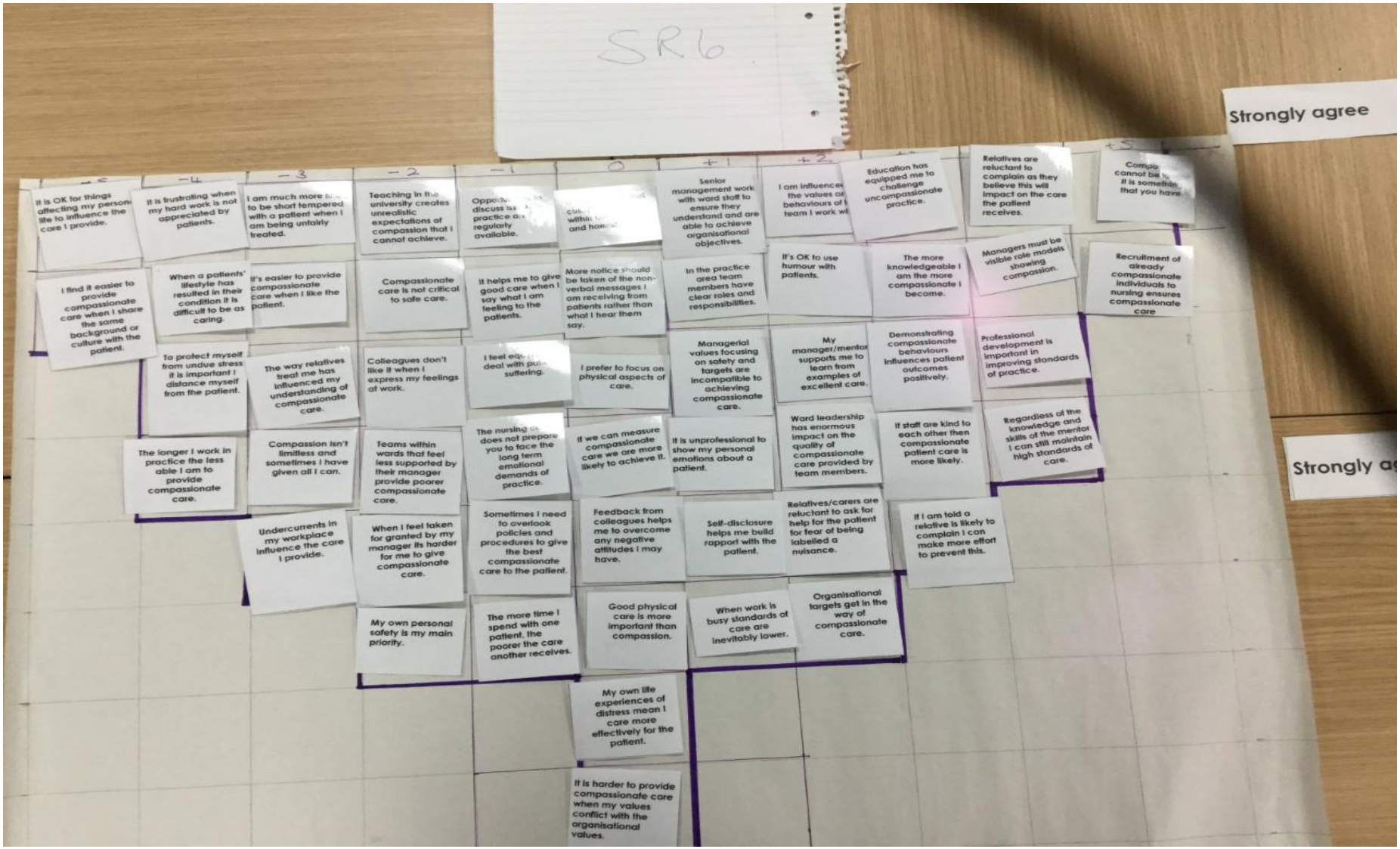
Appendix 19 Final statements in Q sort

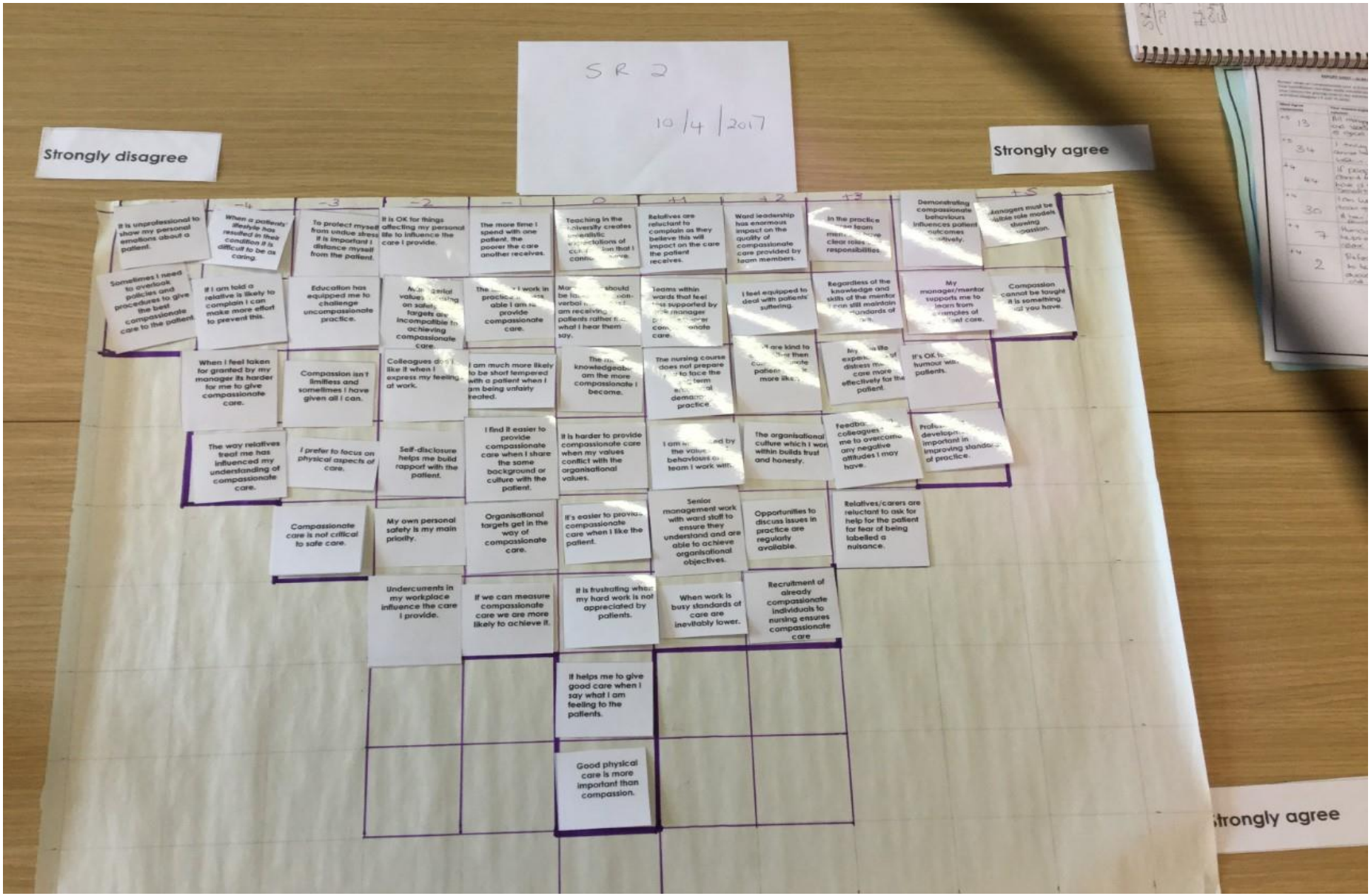
Nurse's viewpoints on compassionate care: A Q method study.
Please place these statements in the order you believe are most to least important in providing compassionate care

1. More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say.
2. Professional development is important in improving standards of practice.
3. It is harder to provide compassionate care when my values conflict with the organisational values.
4. It is unprofessional to show my personal emotions about a patient.
5. It is OK for things affecting my personal life to influence the care I provide.
6. I am much more likely to be short tempered with a patient when I am being unfairly treated.
7. It's OK to use humour with patients.
8. It helps me to give good care when I say what I am feeling to the patients.
9. Colleagues don't like it when I express my feelings at work.
10. It's easier to provide compassionate care when I like the patient.
11. Teaching in the university creates unrealistic expectations of compassion that I cannot achieve.
12. The more time I spend with one patient, the poorer the care another receives.
13. Managers must be visible role models showing compassion.
14. Regardless of the knowledge and skills of the mentor I can still maintain high standards of care.
15. Undercurrents in my workplace influence the care I provide.
16. If we can measure compassionate care we are more likely to achieve it.
17. I prefer to focus on physical aspects of care.
18. It is frustrating when my hard work is not appreciated by patients.
19. I find it easier to provide compassionate care when I share the same background or culture with the patient.
20. The longer I work in practice the less able I am to provide compassionate care.
21. When work is busy standards of care are inevitably lower.
22. Good physical care is more important than compassion.
23. To protect myself from undue stress it is important I distance myself from the patient.
24. When a patients' lifestyle has resulted in their condition it is difficult to be as caring.
25. My own life experiences of distress mean I care more effectively for the patient.
26. Compassionate care is not critical to safe care.
27. Organisational targets get in the way of compassionate care.
28. If staff are kind to each other then compassionate patient care is more likely.
29. I am influenced by the values and behaviours of the team I work with.
30. My manager/mentor supports me to learn from examples of excellent care.
31. When I feel taken for granted by my manager its harder for me to give compassionate care.
32. Self-disclosure helps me build rapport with the patient.
33. The more knowledgeable I am the more compassionate I become.
34. Compassion cannot be taught it is something that you have.
35. Managerial values focusing on safety and targets are incompatible to achieving compassionate care.
36. Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.

37. Feedback from colleagues helps me to overcome any negative attitudes I may have.
38. If I am told a relative is likely to complain I can make more effort to prevent this.
39. My own personal safety is my main priority.
40. Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives.
41. Relatives are reluctant to complain as they believe this will impact on the care the patient receives.
42. Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance.
43. The organisational culture which I work within builds trust and honesty.
44. Demonstrating compassionate behaviours influences patient outcomes positively.
45. Ward leadership has enormous impact on the quality of compassionate care provided by team members.
46. Teams within wards that feel less supported by their manager provide poorer compassionate care.
47. Opportunities to discuss issues in practice are regularly available.
48. Recruitment of already compassionate individuals to nursing ensures compassionate care.
49. In the practice area team members have clear roles and responsibilities.
50. The nursing course does not prepare you to face the long term emotional demands of practice.
51. Compassion isn't limitless and sometimes I have given all I can.
52. The way relatives treat me has influenced my understanding of compassionate care.
53. I feel equipped to deal with patients' suffering.
54. Education has equipped me to challenge uncompassionate practice.

Appendix 20 - Examples of participants' completed Q sorts




SR 2
10/4/2017
Strongly disagree
Strongly agree
-4
-3
-2
-1
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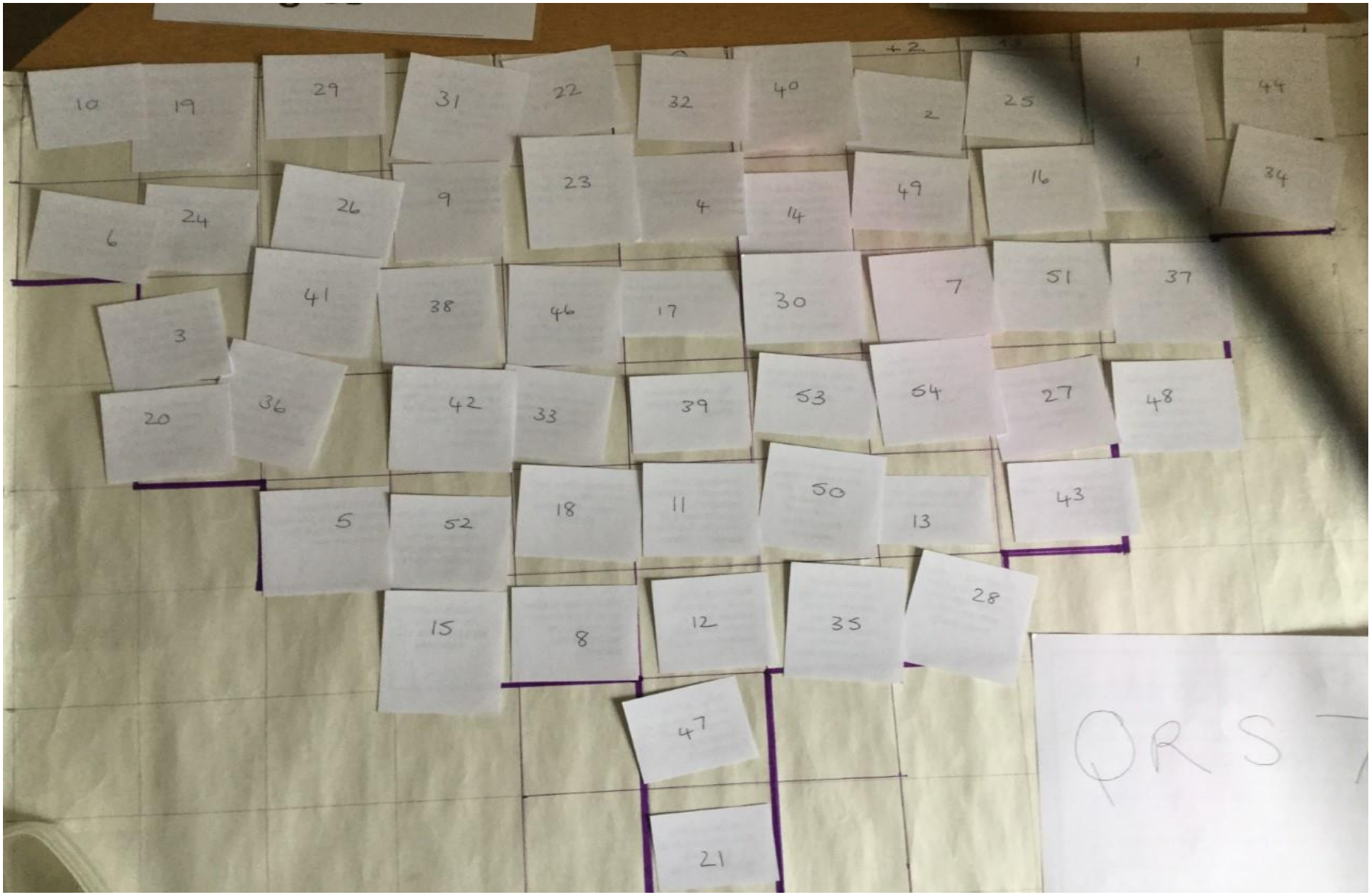
+1
+2
+3
+4
+5
It is unprofessional to show my personal emotions about a patient.
When a patients lifestyle has resulted in their condition it is difficult to be as caring.
To protect myself from undue stress it is important I distance myself from the patient.
It is OK for things affecting my personal life to influence the care I provide.
The more time I spend with one patient, the poorer the care another receives.
Teaching in the university creates unrealistic expectations of [illegible] that I cannot achieve.
Relatives are reluctant to complain as they believe this will impact on the care the patient receives.
Ward leadership has enormous impact on the quality of compassionate care provided by team members.
In the practice [illegible] team members [illegible] clear roles and responsibilities
Demonstrating compassionate behaviours influences patient outcomes [illegible]vely.
Managers must be visible role models showing [illegible]assion.
Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.
If I am told a relative is likely to complain I can make more effort to prevent this.
Education has equipped me to challenge uncompassionate practice.
[illegible] values [illegible] on safety targets are incompatible to achieving compassionate care.
The [illegible] I work in practice [illegible] able I am to provide compassionate care.
[illegible] should be [illegible] non-verbal [illegible] am receiving patients rather than what I hear them say.
Teams within wards that feel [illegible] supported by [illegible] manager [illegible] compassionate care.
I feel equipped to deal with patients' suffering.
Regardless of the knowledge and skills of the mentor [illegible] can still maintain [illegible] standards of [illegible]
My manager/mentor supports me to learn from [illegible] examples of [illegible] care.
Compassion cannot be taught it is something [illegible] you have.
When I feel taken for granted by my manager its harder for me to give compassionate care.
Compassion isn't limitless and sometimes I have given all I can.
Colleagues don't like it when I express my feelings at work.
I am much more likely to be short tempered with a patient when I am being unfairly treated.
The [illegible] knowledgeable am the more compassionate I become.
The nursing course does not prepare [illegible] to face the [illegible] term [illegible] demands of practice.
[illegible] are kind to [illegible] than [illegible] patients [illegible] more likely.
[illegible] experience [illegible] distress me care more effectively for the patient.
If's OK to [illegible] humour with patients.
The way relatives treat me has influenced my understanding of compassionate care.
I prefer to focus on physical aspects of care.
Self-disclosure helps me build rapport with the patient.
I find it easier to provide compassionate care when I share the same background or culture with the patient.
It is harder to provide compassionate care when my values conflict with the organisational values.
I am [illegible] by the value behaviours [illegible] team I work with.
The organisational culture which I work within builds trust and honesty.
Feedback [illegible] colleagues [illegible] me to overcome any negative attitudes I may have.
Profess[illegible] develop[illegible] important in improving standards of practice.
Compassionate care is not critical to safe care.
My own personal safety is my main priority.
Organisational targets get in the way of compassionate care.
It's easier to provide compassionate care when I like the patient.
Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives.
Opportunities to discuss issues in practice are regularly available.
Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance.
Undercurrents in my workplace influence the care I provide.
If we can measure compassionate care we are more likely to achieve it.
It is frustrating when my hard work is not appreciated by patients.
When work is busy standards of care are inevitably lower.
Recruitment of already compassionate individuals to nursing ensures compassionate care
It helps me to give good care when I say what I am feeling to the patients.
Good physical care is more important than compassion.
Strongly agree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QRS

Condition of Instruction

Please sort the cards in relation to your own viewpoint on compassionate care.

To assist you in this task, I have provided the scale that is spread out across the table top and that ranges from +5 on the right to –5 on the left, with 0 in the middle. Your task will be to represent your own view by placing those statements with which you most agree under +5, those with which you next-most agree under +4, and so forth … on down to the statements with which you most disagree under –5, so that all 54 statements are spread out in front of you.

To help with this task, first read through all of the statements and begin the sorting process by dividing the statements into three piles—one pile on the right containing those statements that you agree with, another pile on the left for those that you disagree with, and then a pile in the middle that contains all the other statements. This middle pile may contain statements that don't really matter to you, those that you don't understand, those that you might feel ambivalent about (maybe agreeing with part of the statement and disagreeing with the other part), and so forth. These three piles don't have to be exactly equal in number, but you will find the next part of the task is easier if the three piles are roughly comparable in size, so if you find that you are agreeing with too many or disagreeing with too many, then tighten up your criteria somewhat so as to produce roughly equal numbers of statements in each of the three piles.

Following this process then re-consider the statements in the piles to rank order them in more detail across the scale.

Appendix 22 – Crib sheet supporting factor interpretations

Adapted from Watts and Stenner (2012 p. 154) Doing Q Methodological Research. Theory, Method and Interpretation

Factor 1 = *'There are challenges, but we are working to achieve compassionate care together'* **Factor 2** = *'Organisational targets and workload pressures result in lower standards, limiting the provision of compassionate care'*			
	Items ranked at +5	**Factor 1**	**Factor 2**
13	Managers must be visible role models showing compassion.	+5	0
44	Demonstrating compassionate behaviours influences patient outcomes positively.	+5	+2
	Items ranked at +4		
2	Professional development is important in improving standards of practice.	+4	+3
14	Regardless of the knowledge and skills of the mentor I can still maintain high standards of care.	+4	+1
30	My manager/mentor supports me to learn from examples of excellent care.	+4	+2
45	Ward leadership has enormous impact on the quality of compassionate care provided by team members.	+4	-2
	Items Ranked Higher in Factor 1 Array than in Factor 2 Array		
1	More notice should be taken of the non-verbal messages I am receiving from patients rather than what I hear them say.	+2	+1
4	It is unprofessional to show my personal emotions about a patient.	0	-4
9	Colleagues don't like it when I express my feelings at work.	0	-3
16	If we can measure compassionate care we are more likely to achieve it.	0	-2
17	I prefer to focus on physical aspects of care.	-3	-3
28	If staff are kind to each other then compassionate patient care is more likely.	+3	+2
33	The more knowledgeable I am the more compassionate I become.	+3	-2
37	Feedback from colleagues helps me to overcome any negative attitudes I may have.	+2	-4
38	If I am told a relative is likely to complain I can make more effort to prevent this.	0	-1
39	My own personal safety is my main priority.	-2	-3
40	Senior management work with ward staff to ensure they understand and are able to achieve organisational objectives.	+1	-4

41	Relatives are reluctant to complain as they believe this will impact on the care the patient receives.	+2	-2
42	Relatives/carers are reluctant to ask for help for the patient for fear of being labelled a nuisance.	+1	-1
43	The organisational culture which I work within builds trust and honesty.	+3	0
46	Teams within wards that feel less supported by their manager provide poorer compassionate care.	+2	0
47	Opportunities to discuss issues in practice are regularly available.	1	-4
48	Recruitment of already compassionate individuals to nursing ensures compassionate care.	+3	-2
49	In the practice area team members have clear roles and responsibilities.	+2	-3
53	I feel equipped to deal with patients' suffering.	+1	+1
	Items Ranked Lower in Factor 1 Array than in Factor 2 Array		
3	It is harder to provide compassionate care when my values conflict with the organisational values.	0	+2
6	I am much more likely to be short tempered with a patient when I am being unfairly treated.	-3	-1
7	It's OK to use humour with patients.	+2	+4
8	It helps me to give good care when I say what I am feeling to the patients.	-1	+3
11	Teaching in the university creates unrealistic expectations of compassion that I cannot achieve.	-1	-1
15	Undercurrents in my workplace influence the care I provide.	-2	0
18	It is frustrating when my hard work is not appreciated by patients.	-2	0
19	I find it easier to provide compassionate care when I share the same background or culture with the patient.	-3	+3
21	When work is busy standards of care are inevitably lower.	-2	+5
22	Good physical care is more important than compassion.	-3	-2
25	My own life experiences of distress mean I care more effectively for the patient.	0	+4
26	Compassionate care is not critical to safe care.	-2	+1
27	Organisational targets get in the way of compassionate care.	0	+4
29	I am influenced by the values and behaviours of the team I work with.	0	0
31	When I feel taken for granted by my manager it's harder for me to give compassionate care.	-3	+1
32	Self-disclosure helps me build rapport with the patient.	-1	0
34	Compassion cannot be taught it is something that you have.	+3	+5

35	Managerial values focusing on safety and targets are incompatible to achieving compassionate care.	-1	+2
36	Sometimes I need to overlook policies and procedures to give the best compassionate care to the patient.	-2	-1
50	The nursing course does not prepare you to face the long-term emotional demands of practice.	+1	+3
51	Compassion isn't limitless and sometimes I have given all I can.	-1	+4
52	The way relatives treat me has influenced my understanding of compassionate care.	-1	0
54	Education has equipped me to challenge uncompassionate practice.	+1	+3
	Items ranked at -5		
5	It is OK for things affecting my personal life to influence the care I provide.	-5	-5
20	The longer I work in practice the less able I am to provide compassionate care.	-5	-1
	Items ranked at -4		
10	It's easier to provide compassionate care when I like the patient.	-4	+2
12	The more time I spend with one patient, the poorer the care another receives.	-4	+1
23	To protect myself from undue stress it is important I distance myself from the patient.	-4	-5
24	When a patients' lifestyle has resulted in their condition it is difficult to be as caring.	-4	-3

Appendix 23 – Poster and PowerPoint presentation presented at research conference

UNIVERSITY OF WOLVERHAMPTON

Ann Philp, doctoral student undertaking the Professional Doctorate in Health and Wellbeing at the University of Wolverhampton.

WHO CARES?

Nurses' views on compassionate care:

a study using Q methodology

- WHAT ARE THE VIEWS OF NURSES ABOUT COMPASSIONATE CARE.
- FOR NURSES, WHAT FACTORS PROMOTE COMPASSIONATE CARE.
- FOR NURSES, WHAT FACTORS INHIBIT COMPASSIONATE CARE.
- HOW DO NURSES ACHIEVE AND MAINTAIN COMPASSIONATE CARE.

Context:

In health care there is an expectation that nurses will provide compassionate care, yet there is a recognised tension with competing professional and organisational demands, a rapidly changing working environment, and the resulting emotional demands placed on staff.

The aim of this study in progress is to explore the views from both 3rd year students and qualified nurses on compassionate care and their beliefs of enabling and inhibiting factors to providing this. Also their beliefs of how nurses achieve and maintain compassionate care.

Methods

Q-methodology has been identified as a method for the analysis of subjective viewpoints and has the strengths of both qualitative and quantitative methods. It shares with qualitative methodologies the aim of exploring subjectivity; however, statistical techniques are used to reveal the structure of views.

Participants

The research will involve 15 3rd year nursing students studying the BNurs (Hons) Adult Nursing course with the University of Wolverhampton and experiencing their 'hub' practice placements at The Royal Wolverhampton Hospitals NHS Trust, and also 15 qualified staff employed by the same Trust.

Data

Q-studies require the production of a vast set of statements representing as many different viewpoints on a given topic as possible (the 'concourse'). These were drawn from a comprehensive literature, personal experience and expert opinion, and tested for relevance and comprehensiveness through peer validation, consultation with the doctoral supervisory team and in a pre-pilot stage with a small independent sample from each population resulting in a final total of 54 statements.

The next stage was Piloting the Q set and the Report Sheet to provide insight into participant decision making and to then make any necessary modifications.

In the final stage of the research, participants rank-ordered the statements within the Q set to represent their levels of agreement or disagreement with each statement; completed a Report Sheet; and participated in a post Q-sort interview to provide further insight to their decision making. The results from the Q set sorting process was then factor-analysed using Q-method software (PQMethod) to render visible, factors of items that had statistical significance for the participants. The Report Sheet and interview data will be qualitatively analysed.

Emerging findings

Following factor analysis 2 Factors were identified, both statistically significant.

Factor 1 – *'We are achieving compassionate care together'*

Eigenvalue 10.3174 – 34% common variance. In total 21 participants had commonalities that developed this factor. 10 nursing students and 11 qualified nurses. Participants in this factor:

- Identify there is a positive organisational culture and support from management and team.
- Acknowledge the positive influence of the working relationship and collaboration within the team.
- Do not allow personal situation; feelings; beliefs and values; the way they were being treated; or workload issues to impact on compassionate care.
- Believe the more knowledgeable - the more compassionate.
- Identify that relatives are reluctant to voice concerns.

Factor 2 – *'I need support as targets and workload get in the way of compassionate care'*

Eigenvalue 1.9768 – 7% common variance. In total 9 participants had commonalities that developed this factor. 5 nursing students and 4 qualified nurses. Participants in this factor:

- View the role of, and support from, the organisation /management negatively and identify increased workload results in lower standards.
- Identify that it is not unprofessional or unacceptable to use their own personality, feelings and experience in the care encounter.
- Recognise that compassion is not limitless and sometimes they have given all they can.
- Consider more knowledge does not equate to more compassion.
- Believe that relatives do not feel concern to voice requests.

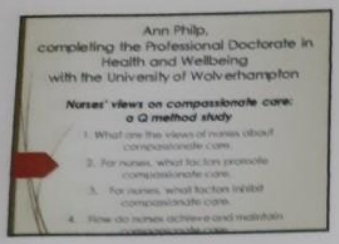
Commonalities between Factor 1 and Factor 2. *(Emerging influences for practice).*

- Compassionate care is achievable and desirable, but we need to build on enablers and overcome barriers.
- The importance of the nurse-patient relationship.
- Self-protection is not a priority when providing compassionate care.
- Education does have an influence, but more understanding is needed of its impact on compassionate care.
- Attempting to measure CC will not make achievement more likely.

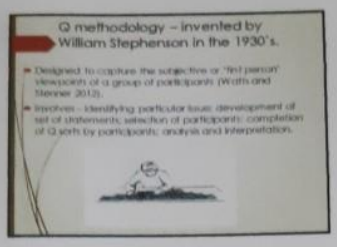
Qualitative analysis of data from Report Sheets and post Q-sort interviews is ongoing.

The results from this study will provide unique insights and potential recommendations to support nurses to achieve and maintain compassionate care in practice. Also providers of nurse education may consider the results to inform future curriculum content and development.

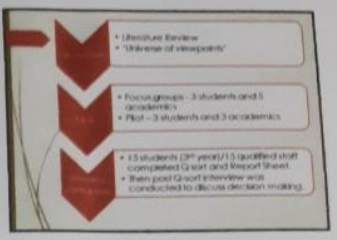
References:* Brown, S.R. (1993)** A primer on Q methodology. Operant subjectivity [online]. 16(3/4), pp. 91-138 ***Christiansen, A., O'Brien, M.R., Kirton, J.A., Zubairu, K. & Bray, L. 2015, "Delivering compassionate care: the enablers and barriers". British Journal of Nursing, vol. 24, no. 16, pp. 833-837. ***Jones, J., Winch, S., Strube, P., Mitchell, M. & Henderson, A. 2016,*** "Delivering compassionate care in intensive care units: nurses' perceptions of enablers and barriers". Journal of advanced nursing, vol. 72, no. 12, pp. 3137-3146 ***Stephenson, W. (1935)*** Technique of factor analysis. Nature [online] ***Watts, S. and Stenner, P. (2012)*** Doing Q methodological research: Theory, method & interpretation.


Ann Philp,
completing the Professional Doctorate in Health and Wellbeing
with the University of Wolverhampton
Nurses' views on compassionate care: a Q method study
1. What are the views of nurses about compassionate care.
2. For nurses, what factors promote compassionate care.
3. For nurses, what factors inhibit compassionate care.
4. How do nurses achieve and maintain

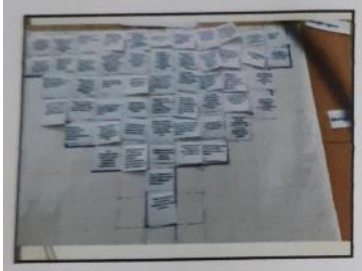
1


Q methodology – invented by William Stephenson in the 1930's.
Designed to capture the subjective or "first person" viewpoints of a group of participants (Watts and Stenner 2012).
Involves - identifying particular issue; development of set of statements; selection of participants; completion of Q sorts by participants; analysis and interpretation.

2


• Literature Review
• 'Universe of viewpoints'
• Focus groups - 3 students and 5 academics
• Pilot – 3 students and 3 academics
• 15 students (3rd year)/15 qualified staff completed Q sort and Report Sheet
• Then post Q-sort interview was conducted to discuss decision making.

3



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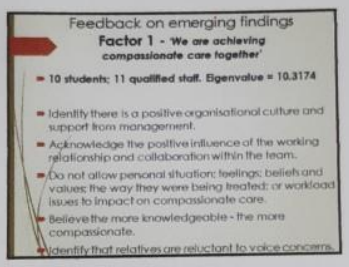
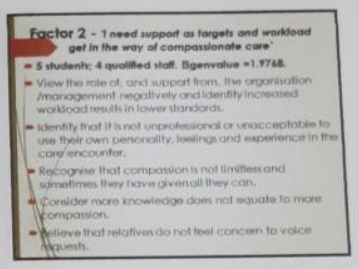
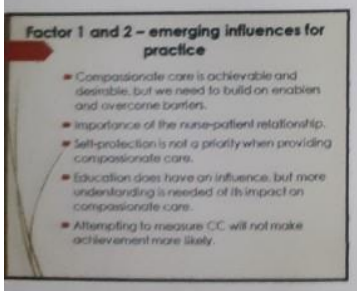

Feedback on emerging findings
Factor 1 - 'We are achieving compassionate care together'
10 students; 11 qualified staff. Eigenvalue = 10.3174
Identify there is a positive organisational culture and support from management.
Acknowledge the positive influence of the working relationship and collaboration within the team.
Do not allow personal situation; feelings; beliefs and values; the way they were being treated; or workload issues to impact on compassionate care.
Believe the more knowledgeable - the more compassionate.
Identify that relatives are reluctant to voice concerns.

5


Factor 2 - 'I need support as targets and workload get in the way of compassionate care'
5 students; 4 qualified staff. Eigenvalue =1.9768.
View the role of, and support from, the organisation /management negatively and identify increased workload results in lower standards.
Identify that it is not unprofessional or unacceptable to use their own personality, feelings and experience in the care encounter.
Recognise that compassion is not limitless and sometimes they have given all they can.
Consider more knowledge does not equate to more compassion.
Believe that relatives do not feel concern to voice requests.

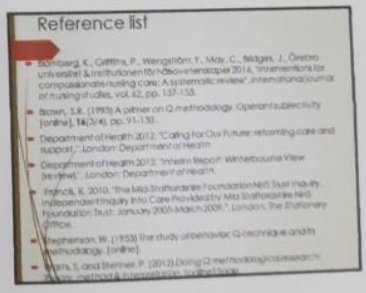
6


Factor 1 and 2 – emerging influences for practice
Compassionate care is achievable and desirable, but we need to build on enablers and overcome barriers.
Importance of the nurse-patient relationship.
Self-protection is not a priority when providing compassionate care.
Education does have an influence, but more understanding is needed of its impact on compassionate care.
Attempting to measure CC will not make achievement more likely.

7


By remembering.....
WHY DID YOU WANT TO BECOME A NURSE?
Treat Others the Way You want to be Treated
How do you believe nurses maintain compassionate care...
'By avoiding judgements and treating patient individually with their needs being the centre of care, can the nurse provide care that is compassionate influencing the patient positively'

8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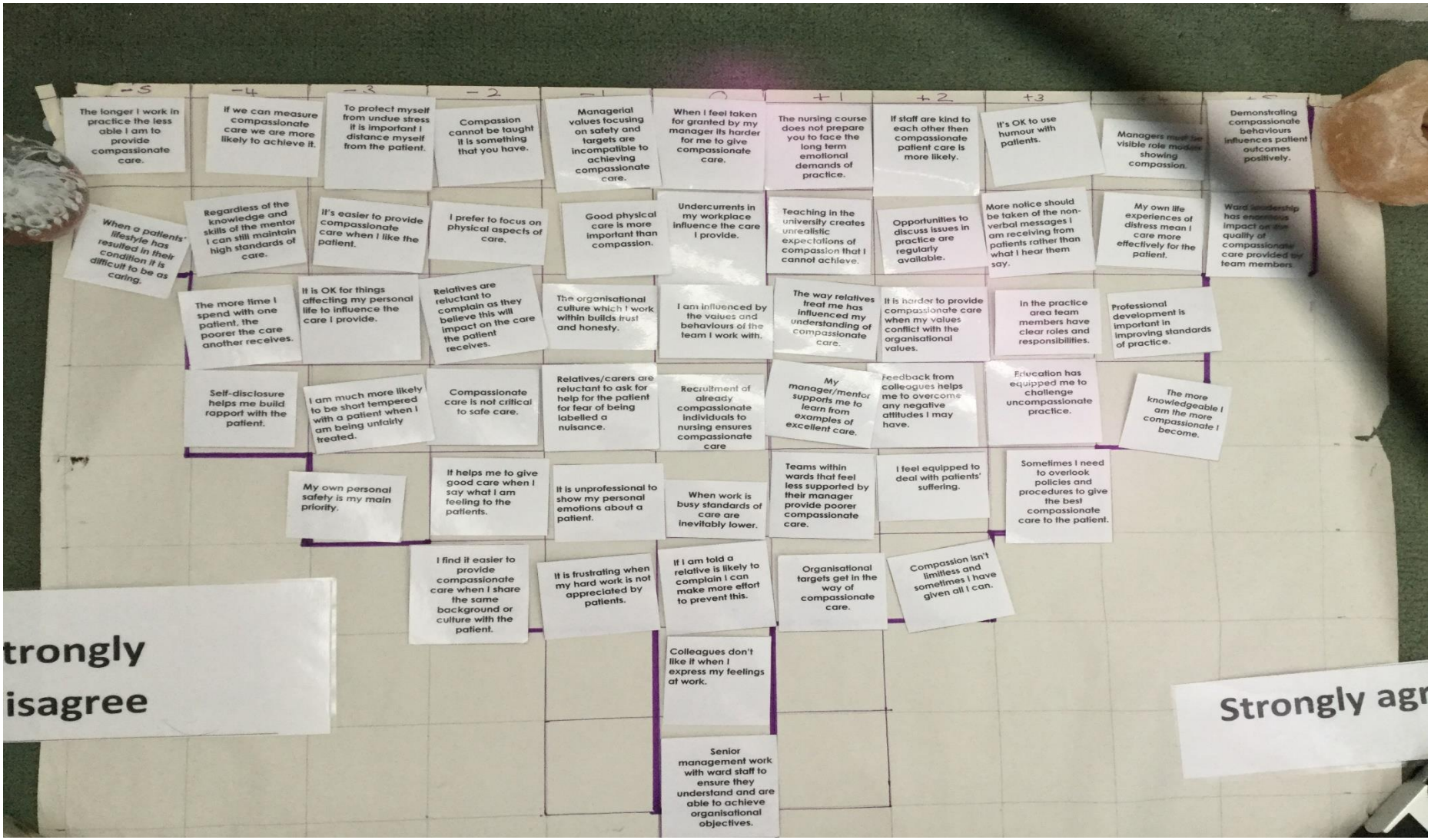
Stephenson, W. (1953) The study of behavior: Q-technique and its methodology. [online].

9

Appendix 24 – The completed Q sort of the researcher



Appendix 25 – Correlation matrix between sorts

Sorts	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
S1	100	17	13	34	-15	24	20	9	17	25	21	3	35	11	11	13	39	10	-12	3	46	8	-13	8	-13	15	-10	39	19	18
S2	17	100	57	21	35	54	33	40	58	55	-10	25	34	36	49	25	47	51	49	56	34	51	40	31	37	37	52	38	38	46
S3	13	57	100	45	33	43	33	37	42	35	10	48	7	35	43	37	42	45	42	34	36	55	46	27	25	47	32	25	48	51
S4	34	21	45	100	4	24	20	22	19	27	45	16	19	3	32	19	42	23	7	11	33	10	-2	6	-13	20	-3	12	12	24
S5	-15	35	33	4	100	25	40	30	43	27	-8	15	10	33	29	43	15	52	34	36	22	33	33	1	44	23	34	9	16	37
S6	24	54	43	24	25	100	45	59	44	53	-6	19	48	43	64	38	42	51	50	53	53	56	44	49	35	37	57	15	40	54
S7	20	33	33	20	40	45	100	38	56	52	-7	43	31	44	34	54	40	43	23	18	29	58	28	29	24	26	18	28	39	39
S8	9	40	37	22	30	59	38	100	40	39	18	25	38	34	64	38	39	49	40	40	34	60	44	52	27	30	59	23	35	62
S9	17	58	62	19	43	44	56	40	100	51	-3	38	23	40	46	56	38	54	41	48	35	63	49	23	39	52	31	38	54	42
S10	25	55	35	27	27	53	52	39	51	100	-17	19	46	53	28	49	41	50	52	33	47	43	46	37	31	25	39	31	29	44
S11	21	-10	10	45	-8	-6	-7	18	-3	-17	100	11	-17	-19	14	2	17	-8	-12	-14	7	2	-17	10	-30	4	-3	7	-2	8
S12	3	25	48	16	15	19	43	25	38	19	11	100	-14	12	37	31	26	26	21	-7	11	30	23	32	7	36	7	24	42	30
S13	35	34	7	19	10	48	31	38	23	46	-17	-14	100	39	29	34	55	42	23	49	41	38	27	30	39	27	29	12	38	40
S14	11	36	35	3	33	43	44	34	40	53	-19	12	39	100	33	31	35	57	42	35	26	49	40	21	46	33	33	21	39	27
S15	11	49	63	32	29	64	34	64	46	28	14	37	29	33	100	37	44	49	39	45	25	54	53	36	35	41	47	21	50	65
Q1	13	25	37	19	43	38	54	38	56	49	2	31	34	31	37	100	29	34	34	22	35	50	40	39	38	30	28	34	56	45
Q2	39	47	42	42	15	42	40	39	38	41	17	26	55	35	44	29	100	31	25	35	43	40	25	33	14	31	31	40	34	44
Q3	10	51	45	23	52	51	43	49	54	50	-8	26	42	57	49	34	31	100	45	56	31	51	36	22	39	48	44	11	31	42
Q4	-12	49	42	7	34	50	23	40	41	52	-12	21	23	42	39	34	25	45	100	54	37	47	48	33	38	31	59	7	29	39
Q5	3	56	34	11	36	53	18	40	48	33	-14	-7	49	35	45	22	35	56	54	100	37	43	48	23	49	39	58	8	33	40
Q6	46	34	36	33	22	53	29	34	35	47	7	11	41	26	25	35	43	31	37	37	100	22	16	44	28	41	26	20	24	31
Q7	8	51	55	10	33	56	58	60	63	43	2	30	38	49	54	50	40	51	47	43	22	100	41	43	21	29	51	34	51	60
Q8	-13	40	46	-2	33	44	28	44	49	46	-17	23	27	40	53	40	25	36	48	48	16	41	100	26	55	29	49	15	36	32
Q9	8	31	27	6	1	49	29	52	23	37	10	32	30	21	36	39	33	22	33	23	44	43	26	100	27	37	31	15	30	38
Q10	-13	37	25	-13	44	35	24	27	39	31	-30	7	39	46	35	38	14	39	38	49	28	21	55	27	100	47	28	6	45	25
Q11	15	37	47	20	23	37	26	30	52	25	4	36	27	33	41	30	31	48	31	39	41	29	29	37	47	100	10	10	37	24
Q12	-10	52	32	-3	34	57	18	59	31	39	-3	7	29	33	47	28	31	44	59	58	26	51	49	31	28	10	100	16	30	54
Q13	39	38	25	12	9	15	28	23	38	31	7	24	12	21	21	34	40	11	7	8	20	34	15	15	6	10	16	100	31	22
Q14	19	38	48	12	16	40	39	35	54	29	-2	42	38	39	50	56	34	31	29	33	24	51	36	30	45	37	30	31	100	49
Q15	18	46	51	24	37	54	39	62	42	44	8	30	40	27	65	45	44	42	39	40	31	60	32	38	25	24	54	22	49	100

Appendix 26 – Unrotated factor matrix

Sorts	Factor 1	Factor 2
S1	0.2361	0.4356
S2	0.7034	-0.1135
S3	0.6868	0.2194
S4	0.3219	0.4288
S5	0.4455	-0.2054
S6	0.7515	-0.1202
S7	0.6013	0.0728
S8	0.6958	-0.0295
S9	0.7429	0.0487
S10	0.6709	-0.1070
S11	0.0014	0.4984
S12	0.3856	0.4265
S13	0.5191	-0.1319
S14	0.5732	0.2702
S15	0.7277	0.0274
Q1	0.6280	0.1245
Q2	0.6256	0.2174
Q3	0.6885	-0.2595
Q4	0.5912	-0.3641
Q5	0.6033	-0.4313
Q6	0.5609	0.0872
Q7	0.7388	-0.0033
Q8	0.5750	-0.3008
Q9	0.5097	0.0432
Q10	0.4821	-0.3258
Q11	0.5488	0.0887
Q12	0.5747	-0.4446
Q13	0.3714	0.2461
Q14	0.6226	0.1524
Q15	0.7005	0.0012
Eigenvalues	10.3174	1.9768
% explained variance	34	7